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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

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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.

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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

Brenda Liscler

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

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

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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F 000	INITIAL COMMENT	ΓS	FC	000			
	Revised 2567 as a Resolution, see tag	result of an Informal Dispute F157.					
	as your allegation of Department's accepenrolled in ePOC, yat the bottom of the form. Your electror be used as verificated Upon receipt of an on-site revisit of you validate that substates	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an our facility may be conducted to an arconolia ce with the attained in accordance with		\$ED			
F 157 SS=G	483.10(b)(11) NOT (INJURY/DECLINE) A facility must immedent consult with the resident involving the resident involving the injury and has the printervention; a signification in heast at us in either life the clinical complication significantly (i.e., a existing form of treatment); or a decident from the §483.12(a).			TITLE			2/8/16 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(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 A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 157	and, if known, the ror interested family change in room or specified in §483.1 resident rights under regulations as specified in section. The facility must rethe address and phlegal representative. This REQUIREMED by: Based on interview facility failed to notimanner for 1 of 4 rehospitalization who changes in condition. This resulted in act experienced prolon and vomiting, relate notification and subinpatient facility for Findings include: R46's discharge ordated 9/17/15, iden improving with order occupational therapy indicated diagnoses lumbar region, separations.	so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or sified in paragraph (b)(1) of cord and periodically update one number of the resident's er interested family member. Note the provide ced of the center of the provide ced of the cetter of the provide ced of the pr	F 1	157	The preparatic of the ollowing place are stion for the selfir ency does are consume and smoon not be interpreted as an admission nor an agreement facility of the truth of the facts allege conclusions set forth in the statemed efficiencies. The plan of correction prepared for this deficiency was exposely because provisions of state as federal law require it. Without waive foregoing statement, the facility state with respect to: 1. Resident #21 is physician has updated on a regular basis on the changes in her condition and overa status. Resident #46 is deceased. 2. All resident is were reviewed for change in condition and need to no physician per phone call. All reside orders for insulin were reviewed an corrected where orders to call the physician for high glucose readings standing orders were updated per	not reted by the ed or ent of n ecuted and ing the tes been all or any tify the ent	

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F 157	9/24/15 identified a Status score of 13/2 area assessments. R46's care plan, da cognitive impairment return to the commoditive impairment return to the centimeter on 19/26/11 ilicensed practical in the medication admadministered on 19/26/11 ilicensed practical in the medication had since supper. No fee fectiveness was centry dated 9/26/15 had received anoth stomach and emes listed as had another the other doses administered as had another the other doses administered results documented. A nursing progress 9/25/15 at 8:30 a.m. and complaints of rindicated R46 had it along with Thorazin after his morning medicated and himself.	inimum Data Set (MDS), dated Brief Interview for Mental 15 (cognitively intact). No care were completed with the MDS. Ited 9/30/15 identified no into and that R46 desired to unity. O15 medication sheets eceived Maalox (an antacid) is (cc)'s on 9/25/15 a total of ate, as well as one dose at 5 incompleted. A subsequent of the properties of the properties of the follow up assessment for completed. A subsequent is, at 2:00 am. indicated R46 er dose of Maalox for an upset is; the follow up result was the follow up di. Inote written by LPN-F on indicated R46 had hiccups and feeling well. The notes been given Maalox 30 cc's the and had begun retching edications. In addition, R46 large projectile emesis all over f, and had refused to eat ast, stating he had consumed	F 1	recommendation of our med to notify the physician if two local Glucose results are <70 or > hour period. 3. Education to licensed state completed by 2-3-16 on ensurphysicians are notified in a ticoncerning any resident charactering and that physician obtained for elevated glucose including orders to call the plathere is two blood Glucose re >400 in a 24 hour period. 4. When residents present that the concorn in and iffy the direction of the plathere is two blood glucose re including orders to call the plathere is two blood glucose re including orders to call the plathere is two blood glucose re >400 in a 24 hour period. 5. The DNS or designee with audits weekly for 4 weeks are 2 months to ensure that the fline is being followed correct 6. The data collected will be reviewed/discussed at the quenting. At this time the QA committee will make the decision/recommendation refollow-up studies. The DNS will be responsible Completion Date: 2-8-16 Valley View Manor Plans to I	Blood 400 in a 24 aff will be uring that mely manner nge in orders are e levels, nysician when esults <70 or with a will call the n a timely tor of Nursing an orders are e levels, nysician when esults <70 or Il complete 2 nd weekly for facilities guide ly. e uarterly QA&A garding any for this POC.		

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F 157	on 9/25/15, at 1:39 large emesis, and the was not feeling well hiccups had subsidistarted again. Door received Maalox ar medication used for another small emet documented as had and was described R46's temperature been elevated at 98 and was described R46's temperature been elevated at 98 and was described R46's temperature been elevated at 98 and was described R46's temperature been elevated at 98 and was described R46's temperature been elevated at 98 and was described R46's temperature been elevated at 98 and was described R46's temperature been given determined but that R46 had be feel right and that we was a feeling chilly. A nursing progress p.m. per LPN-F indifference in the power of the po	note documented by LPN-F p.m. indicated R46 had a shat the resident had stated he l. The notes indicated his led for a while but had then umentation indicated R46 had and Thorazine (an antipsychotic r antiemetic properties) with sis afterward. The emesis was ving had food particles present as having a colicky odor. was documented as having 9.0 degrees Fahrenheit (F). In the date of 9.0, 10, at 1:00 ic ted R4 is hid stayed it bed g. The lote is lineated R4 is refer to the ear revening he is attention stated nis turning still drun't whenever he moved he began aten Jell-O for supper and had ionally, the documentation simile) had been sent to 0)-A with an update on R46's that R46 had an elevated of degrees F and complained of the dated 9/25/15, at 11:05 icated R46 had not been ad been having brown colored a afternoon shift which did not been do been having brown colored a afternoon shift which did not been do be of the dated 9/25/15, at 11:05 icated R46 had not been and R46's held due to emesis.	F 1	SED			

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F 157	BM. R46's temp w at 99.1 degrees F. A nursing progress 9/26/15, at 4:48 a.n of emesis, like soft movement) with no indicated R46 was slightly elevated ter R46 had a wasteba continued to wretch A nursing progress 9/26/15, at 9:57 a.n further emesis of g of BM looking in it. an acute care hosp order was received emergency room (Eindicated R46's data agreed to meet him facility at 8:45 a.m. A faxed physician's present in R46's reorder to transfer per hospital. An additional nursing 9/26/15, at 2:06 p.n. admitted to the acute of the service	aving emesis which looked like as noted to be slightly elevated note written by LPN-A on in. indicated R46 had 100 cc's formed/loose BM (bowel odor. The note further cool and clammy, with a imperature at 99.1 degrees F. isket beside him, and	F 1				
	p.m. from the facilit identified that R46	order sent on 9/25/15, at 6:05 y to R46's primary physician had emesis since 8:30 a.m.,					

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F 157	drink. R46 complained had not been signed days later, when the responded with a sitelephone order to Please do NOT fax need attn [attention [physician] - today sfaxing for response. The ER progress man. was reviewed had appeared distributed brown man. The ER note further was firm and diffus with dried brown mand in the error and saline intraventation of the error and saline intraventation. The ER registered and diagnoses of small dehydration. The ER registered 9/26/15, at 11:17 a. he'd been vomiting emesis was now brown liquid running abdomen was very and the abdomen was very and the abdomen was complained of abdomen of the error and the complained of abdomen was complained of abdomen was very and the abdomen was very and the abdomen was very and the abdomen of abdomen was very and the abdomen was very	ge 5 and had been unable to eat or ned of feeling weak. The fax d off until on 9/28/15, three enurse practitioner (NP)-A tatement including, "Noting transfer to ER on 9/26/15. In regard to situations that I that day. This will be sent to 9/28/15. Please review the procedure. Thx [Thanks]." The ER note indicated R46 essed when examined, had estated of the examined, had estated of the examined of	F 15	BED		

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F 157	fluid output after whoteter. R46 was alwhat ever we have The hospital dischaindicated R46 had to correct the small developed subsequanticoagulation issileus (disruption in surgery. The ileus of a nasogastric tult were initiated and F During interview on director of nursing expected staff to commediately with the specially when the BM-type material a During interview on nursing home's head coordinator/nursing LPN-B was not well hospital intensive conterview. The HIM pool nursing staff. During interview on acting administrato the time of the incidental R46's family had in hospital with a bow later been found to administrator was uregarding R46's ep	r ten minutes with 1400 mL of nich R46 stated he felt much ert and "states we should do to do. Is comfortable now." arge summary dated 10/5/15, undergone abdominal surgery bowel obstruction, and had ues as well as post-operative normal bowel motility) after the resolved with the replacement oe; however, comfort cares R46 passed away on 10/5/15. 11/29/1! at 1:07 p.m. re (E xiv, erifie sine would have eurgent cinical issues, e resident was vomiting and not feeling better.	F 15	SED		

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F 157	directly with concer administrator stated staff to check the vistatus, appetite and a physical assessm she thought LPN-A her judgment. She every Thursday nig When LPN-A was in on 12/29/15 at 4:02 received report from on 9/25/15, regarding been unaware a fastated she'd worked prior and was awar complaints of not fee She was aware R44 been eating well, an administered Maalox first time she admir LPN-A verified R46 like stool but there abdomen had also LPN-A was unawar complained of pain subsequently vomit later in her shift (are she'd become concomething wrong we said she'd proceed paperwork for a hor not call the RN on the concern. LPN-along the paperworn nurse, LPN-B, who	call and/or primary physician ins that were urgent. The dishe would have expected the tal signs, bowel movement if fever status while conducting itent. The administrator stated was a good nurse and trusted further verified LPN-A worked that shift. Interviewed about the incident in the evening nurse (LPN-F) in the evening nurse (LPN-	F 15	BED		

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F 157	During the interview there had been a high she had noted whe pass along to the discovery and the had been a discovery and the had been a discovery and the hospital and the hospital. The malthough R46 may anyway, prompt me him comfortable. The flect of delayed might related to R46's me state since she was a During interview on medical doctor (ME stated he would had called the clinic and R46 began vomiting stated faxing medic p.m. was inappropring the hospital attended at the he'd been concerned is chemic bowel who due to the delay in after his symptoms made some "depreed to the discovery and the hospital attended at the discovery and the hospital and the clinic and R46 began vomiting stated faxing medic p.m. was inappropring the highest properties the delay in after his symptoms made some "depreed to the delay in after his symptoms made some "depreed to the delay in after his symptoms made some "depreed to the delay in after his symptoms made some "depreed to the delay in after his symptoms made some "depreed to the delay in after his symptoms made some "depreed to the delay in after his symptoms made some "depreed to the delay in a the high the following the following the high the	ollow up on R46's condition. v, LPN-A stated she thought istory of small bowel concerns in filling out the paperwork to ay shift personnel. Interview on 12/30/15, at 9:12 attor stated LPN-A should have an sooner about R46's tishe had not been aware elay in his nursing care and	F 1	SED			

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were a "sidebar" an issue. MD-A confirmore comfortable it sooner in the ER. I vomiting brown stuff you are seen." The facility's policy SBAR last revised anotification of the playmptom, sign or a sudden in onset, a severe) in relation that and was unrelieved prescribed. The posection related to a immediate notification required when there of marked tenderned (gastrointestinal) blast 10(g)(1) RIGHT READILY ACCESS A resident has the resident of the most recent sure federal or State succorrection in effect. The facility must make a manufaction and make a manufaction a	and were not relevant to this med R46 would have been in the had been examined MD-A stated, "when you are if, it is probably a good idea if the entitled Change in Condition 3/15, indicated immediate thysician was required for any parent discomfort that was marked change (i.e. more to usual signs and symptoms allow measures already the interest of the physician was the ras ra, id to set, or presence as s, fever, volunting or Gleeding. In To Survey Results - Its results of the facility conducted by responsible to the facility. The examine the results of the facility with respect to the facility. The examine the results of the facility and any plan of the facility and must post a notice of the facility and must post a notice of the facility post in a place readily ents and must post a notice of the facility post in a place readily ents and must post a notice of the facility post in a place readily ents and must post a notice of the facility post in a place readily ents and must post a notice of the facility post in a place readily ents and must post a notice of the facility post in a place readily ents and must post a notice of the facility post in a place readily ents and must post a notice of the facility post in a place readily ents and must post a notice of the facility post in a place readily ents and must post a notice of the facility post in a place readily ents and must post a notice of the facility post in a place readily ents and must post a notice of the facility post in a place readily ents and must post a notice of the facility post in a place readily ents and must post a notice of the facility post in a place readily ents and must post and the post in a place readily ents and the facility post in a place readily ents and the facility post in a place readily ents and the facility post in a place readily ents and the facility post in a place readily ents and the facility post in a place readily ents and the facility post in a place readily ents and the facility post in a place readily ents and the f		BED	2/8/16
Based on observat	tion, interview, and document		The preparation of the following pla	an of
	PROVIDER OR SUPPLIER VIEW MANOR HCC SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa were a "sidebar" an issue. MD-A confir more comfortable if sooner in the ER. I vomiting brown stuf you are seen." The facility's policy SBAR last revised 3 notification of the pl symptom, sign or a sudden in onset, a severe) in relation t and was unrelieved prescribed. The po section related to a immediate notificati required when there of marked tenderne (gastrointestinal) bl 483.10(g)(1) RIGHT READILY ACCESS A resident has the r the most recent sur Federal or State su correction in effect The facility must ma examination and m accessible to resid their availability.	PROVIDER OR SUPPLIER VIEW MANOR HCC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 poli y man, Y in postion that immediate notification on the physician was required when there was ra, id c set, or pres right of marked tenderness, fever, yournary or GI (gastrointestinal) bleeding. 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	PROVIDER OR SUPPLIER VIEW MANOR HCC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 poli y name of its insign that immediate notification of the poli y name of its insign that immediate notification of the poli y name of its insign that immediate notification of the poli y name of its insign that immediate notification of the poli of the poli of the insign	PROVIDER OR SUPPLIER VIEW MANOR HCC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 were a "Sidebar" and were not relevant to this issue. MD-A confirmed P46 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 poli y now Y ir section related to ab brinina its instant tha immediate notification. ". eph) weam was required when there as ra, id c set, or pres r. e of marked tenderness, fever, vomuning or GI (gastrointestinal) bleeding. 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:

_	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245378	B. WING		1	2/31/2015	
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP 200 EAST NINTH AVENUE LAMBERTON, MN 56152	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE	
F 167	current survey resureadily accessible to visitors. This had the residents currently in Findings include: During the initial toudirector of nursing (p.m., observations and state survey residents, families of the results are usual board near the nort but confirmed they also be a more than to be be be be be be be be be to be be be to be	ge 10 illed to ensure the most Its were posted in an area or residents, families and e potential to affect all 40 residing in the facility. It of the facility with the DON) on 12/28/15, at 12:00 revealed the current federal sults were not available to or visitors. The DON indicated ally posted on the bulletin h the secondary results, he I is in a in it is binder place inder which included the survey of one reasily accessible to the or visitors. The DON	F 1	correction for this deficience constitute and should not has an admission nor an agracility of the truth of the faconclusions set forth in the deficiencies. The plan of oprepared for this deficiency solely because provisions federal law require it. With foregoing statement, the fawith respect to: 1. Posting the most curresults in an area readily a residents, families and visitives and the importance of the designated for the current sund the importance of the designated for the current 4. The Administrator or densure that the most currer results are posted in the delocation. The Administrator will do audits 5 times per womonth, then audits three ties 2 months to ensure that the of correction is being follows. The data collected will reviewed/discussed at the meeting. At that time the committee will make the decision/recommendation follow-up studies. The Administrator will be retained to the poor.	be interpreted greement by the acts alleged or estatement of correction y was executed of state and nout waiving the acility states are survey accessible to itors. and visitors will current survey pleted by 2-5-1 egards to urvey results location survey results location survey results lesignee will ent survey esignated or or designee week for 1 mes a week for 1 mes a week for efacilities plarwed. I be quarterly QA&QA&A regarding any	6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245378	B. WING		12/3	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE .AMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 167	Continued From pa			F 167 Completion date: 2-8-16		
F 176 SS=D	DRUGS IF DEEME An individual reside the interdisciplinary	nt may self-administer drugs if team, as defined by	F 176			2/8/16
	practice is safe. This REQUIREMENT by:	NT is not met as evidenced ion, interview, and document		The preparation of the following pla	an of	
	review the facility fa practice of self-adm	illed to ensure the safe ill suauce for or a relidents er ed selacinistering a		correction for this deficiency does no correction for this deficiency does no correction for the interpretas a admission of a agreement cili for the truly hof the facts alleged on coursions second in the statement deficiencies. The plan of correction	ot eted by the ed or ent of	
	Ipratropium-Albuter milligrams/3 millilite	ers dated 12/8/15, included ol solution 0.5-2.5 (3) ers, 1 vial inhale orally three rtness of breath, every 6 hours		prepared for this deficiency was exesolely because provisions of state a federal law require it. Without waivi foregoing statement, the facility stat with respect to: 1. Resident # 6 was transferred to another facility on 1-25-16.	ind ing the tes	
		ım Data Set (MDS) dated R6 had severe cognitive		All residents for whom nebulize treatments are ordered have been reviewed to ensure that nursing statemaining with them during their breatments.	ff are	
	a risk for alteration (r/t) diagnoses of el obstructive pulmonacute episode. His h/o bronchospasms muscles in the walls	e plan dated 10/12/15 included in respiratory status related to mphysema/COPD (chronic ary disease) with recurrent tory of (h/o) pneumonia, and a (sudden constriction of the soft the bronchioles causing The care plan further		treatments. 3. Education will be completed by 16 for all Licensed Nursing staff on administration of nebulizer treatmer include remaining with the resident the entire nebulizer treatment. A cli Competency by Licensed Nursing S will be completed. Each nurse, who	2-3- Its that during nical	

-	OF DEFICIENCIES OF CORRECTION			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245378	B. WING		12/3	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	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 176	included routinely retreatments. Further review of the include evidence of R6's ability to self-action of the include evidence of R6's ability to self-action of the include evidence of R6's ability to self-action of the include evidence of R6's ability to self-action of the include evidence of R6's ability to self-action of the include evidence of R6's ability of the include evidence of R6's ability of the include evidence of the inc	r problem r/t dementia which efusing neb (nebulizer) ne medical record did not an assessment related to dminister medications. 9 p.m. two surveyors on the edge of his bed mask with machine running ed in the nebulizer solution alone in the room with no visualization of the resident. or ximate y 2 50 p.m. lic nsect N w is observed in R6 3 ng on the edge of bed thou? The on 12/31/15, at 9:09 a.m. the DON) confirmed R6 did not not to self administer redication nurse was expected esident throughout a nebulizer N further confirmed C6 had a n-compliant with administration	F 17	signing for completion of the nebuteatment for each resident receive in the MAR, will be trained that by they not only verify that they perform the nebulizer treatment procedure resident but that their signature all verifies that they remained with the resident during the course of their treatment as a necessary part of the procedure. 4. The DNS or designee will contain two audits per week for four week weekly for two months to ensure compliance. The dedical sed at luarterly of the revie red/disculated at luarterly of the revie red/disculated that they decision recommendation regardification follow-up studies. The DNS is responsible for the Position Date: 2-8-16	ing one signing, rmed for the so e nebulizer he nplete s then		
F 248 SS=D	the treatment." 483.15(f)(1) ACTIV INTERESTS/NEED	ITIES MEET	F 24	48		2/8/16	
		ovide for an ongoing programed to meet, in accordance with					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245378	B. WING		12/3	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	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	the comprehensive the physical, menta of each resident. This REQUIREMED by: Based on observareview the facility for 3 (R6, R23) resident for 3 (R6, R23) resident for a complete the portion of the assess of daily and activity resident preferred resident consideration of the resident could complete the portion of the assess of daily and activity resident preferred resident could complete the portion of the asses of daily and activity resident preferred resident could complete the portion of the asses of daily and activity resident preferred resident could complete the portion of the asses of daily and activity resident preferred resident could complete the portion of the asses of daily and activity resident preferred resident could complete the portion of the asses of daily and activity resident preferred resident could complete the portion of the asses of daily and activity resident preferred resident could complete the portion of the asses of daily and activity resident preferred resident could complete the portion of the asses of daily and activity resident preferred resident could complete the portion of the asses of daily and activity resident preferred resident could complete the portion of the asses of daily and activity resident preferred resident could complete the portion of the asses of daily and activity resident preferred resident could complete the portion of the activity resident preferred resident could complete the portion of the activity resident preferred resident could complete the portion of the activity resident preferred resident could be	assessment, the interests and al, and psychosocial well-being NT is not met as evidenced tion, interview, and document alled to provide activities for 2 dents reviewed for activities. It crace 'yo or or or you'th the gement we hout behalioral in the communication deficition in the communication deficition in the control of the contr	F 248	The preparation of the following pleorrection for this deficiency does reconstitute and should not be interpleas an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statemed deficiencies. The plan of correction repleored the solel because provisions of state and the includes more specific activities that appropriate for them. 2. All residents will be reviewed by Activity department to ensure that appropriate activities are in place for them. 3. Education on resident appropriate in the activities will be completed by 2-5-all staff meeting. The activity department to ensure that appropriate activities are in place for them. 3. Education on resident appropriate in the activities will be completed by 2-5-all staff meeting. The activity department activities are in place for them. 3. Education on resident appropriate in the activities will be completed by 2-5-all staff meeting. The activity department activities are in place ach resident. Where difficulties means the activities are in place ach resident. Where difficulties mexist regarding appropriate activities specific residents who are more	not reted by the ed or ent of necuted and ring the ates or each or eac	
	R6's annual Recrea	ation/Wellness Assessment		challenging, the IDT will be enlisted help develop a plan for appropriate		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245378	B. WING _		12/	31/2015
	NAME OF PROVIDER OR SUPPLIER VALLEY VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIF 200 EAST NINTH AVENUE LAMBERTON, MN 56152	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 248	dated 10/4/15, indic R6's son from the passessment identificiparticipation in interspecific interest with rides, visiting in perwalks/bicycling. The past preferences of Charlie Chan movie R6's care plan for a indicated the reside but occasionally nestructuring leisure a wellness. Intervent plan: (1.) CD player in rocresident's desire. (2.) Recreation/Welexercise, listening the wrestling and warn sensory and 1:1 time (3.) EMOTIONAL: Condividual music engence (4.) PHYSICAL: Engence well-Fit program to individual cardio. The would work on puzze period. When interviewed continuous observations are sident through gence continuous observations.	reated information was given by previous assessment. The ed current interests as: group generation programs with a school kids singing, golf cart son/on phone with family, e assessment also included watching wrestling on TV and es. ctivities dated 10/12/15, and was primarily independent eded some guidance with activities that promote ic is ide. 'ifile on the care include: o music, watching TV (enjoys novies) food related activities, i.e. Offer ipod or CD player for	F 24	activities. 4. The Activity Director of complete 2 audits weekly weekly for 2 months to en resident is are receiving a according to their plan of 5. The data collected will reviewed/discussed at the meeting. At this time the committee will make the decision/recommendation follow-up studies. The Activity Director and I Cool make will be reformed. Commendation will be reformed. Commendation at 2-8-1	for 4 weeks and sure that the activities care. Il be quarterly QA&A QA&A regarding any	

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245378	B. WING		12	/31/2015	
	NAME OF PROVIDER OR SUPPLIER VALLEY VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CO 200 EAST NINTH AVENUE LAMBERTON, MN 56152	<u>-</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 248	assistance of two seresidents wheelchar west Cityside hallwest Cit	was ambulated with the taff, a 3rd staff pushed the ay. Staff were responding in lizations. After R6 ambulated all staff seated him back in the tansfer belt and transferred area located by the nurses' and him in front to the television led himself in the w/c room. In gassistant (NA)-A brought sensory item which consisted him with the sensory item which consisted him with the sensory item are purifically. Although R6 do not appear interested nor didepulate or pull the sensory item. after the item was delivered to a the commons area until 1:44 do practical nurse (LPN)-C to his room. If this room via the w/c to plastic mug from the drinking the west hallway. Staff he task, replaced the lid and a water-filled mug, R6 as he propelled the w/c way. It was noted that once R6 of the hallway, staff intercepted					

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F 248	though he appeared time, a popcorn an in the activity room, to attend. At 2:14 p distribute fresh wate immediately. -At 2:30 p.m., R6 w bed in room with the a shoe on his lap, resensory object was music was playing a 4:17 p.m., R6 was remove and replaced Although coffee soo games activities we this time, R6 was neattend. At 3:10 p.m. greeted R6. Trained also entered the roostill "working on his whether R6 was su TMA-A responded and on R6, they could and not worry about assist R6. Observations of R6 following: - At 7:50 a.m. R6 w table in the corner of breakfast independ flush to the wall on the other resident's	d to be wide awake. At this d movie activity was occurring however R6 was not assisted o.m. staff entered the room to er, greeted R6 and left as seated on the edge of his e left shoe off and was holding emoving the laces. The no longer visualized. No in the room. From 2:39 until observed attempting to e the lace from his left shoe. Single and word er held in the dining room at or assimple of the dining room and asked whether R6 was shoe". NA-C asked TMA-A proposed to have the shoe. That if NA-C could get it laced all d transfer him into his chair tit, however NA-C did not on 12/30/15 revealed the as observed seated alone at a of the dining room eating ently. The table was pushed 2 sides. R6 had his back to in the dining room, facing only	F 24	BED		
	by staff to the Citys table. Staff handed shaped sensory ob	m. R6 was assisted in the w/c ide dayroom and placed at a IR6 a multicolored cylinder ject that also made sound Staff then left the area				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
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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	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 248	without further interbehind him on the sto propel self past the dining room to the lowest standing. R6 was standing. R6 was sisted in propelling LPN-C left the residual was lying on his be exposed and beddibed; no pillowcase	raction. R6 placed the object seat of his w/c and proceeded he nurses' station towards the medication cart where LPN-C vocalized loudly. LPN-C at he had already eaten and high him back to his room. dent's room at 8:05 a.m. R6 d with the bare mattress ng in a clump at the end of was on R6's pillow. R6 was nto the grab bar, attempting to	F 24	3			
	the activity room. Rhimself down the waturned the corned, and propelled him to hallway. R6 then erself around the person to he window in the fish tank. R6 direction of the east near this area until R6 from the east hadayroom. No verbainteraction was not offered/assanytime throughout did staff interact with waturned the dayroom by nurses currently in process plan of care as an pa.m. R6 was seated near nurses station.	u machity as conduited in 16 ndepe der ly propelled in 16 ndepe der letered the dayroom, propelling in 16 ndepe der letered the dayroom, propelling in 16 ndepe der letered the dayroom, propelling in 16 ndepe der letered the activity propelled himself toward the 16 ndepe der letered in 16 ndep der letered in 16 ndepe der letered in 16 ndep der l		SED			

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 248	-At 2:35 p.m. R6 was where the men's grain area of the diswere noted to interact out of the dining room at 2:44 p.m. When interviewed of AD stated R6 is very and is scheduled for stated staff will also well as the men's grain to the facility on 12/since. AD stated transcered that an interprete to the facility on 12/since. AD stated transcered for the facility campossible placement to converse with R6 discovered he enjo When requested do activities provided from 1:1's with staff 11/16-11/22/15 R6 the AD indicated shappogramming with I documentation to dimplemented nor conccurred. AD stated	as observed in the dining room oup activity was held in the ning room. No activity staff act with R6 until they assisted om towards the direction of his on 12/30/15, at 12:41 p.m. the ry "antsy" r/t group activities or in-room programming. AD at 2 in-room activity programs 20 minutes/day. AD also of the offer offer was a last to the ing activities are ingactive was a last to the ingactivities of the had not been returned ying to get hold of the had not been returned. AD ago a representative from the ingactive from the ingactive was able to assess the resident for the representative was able on the instruction related to or R6, the following was a 12/12/15) -R6 received only (11/4 & 11/7). The week of received 1:1 activity. Although the had provided 1:1 in-room R6, she was unable to provide the monstrate this had been outly she offered an Ipod with the listen to music in his own.	F 2				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, 200 EAST NINTH AVENUE LAMBERTON, MN 56152			
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F 248	language. The AD indicating the Ipod November and 4 ti When questioned a (wrestling and war care plan, she indic preferences. When were reviewed to si resident had attend highlighted and/or chad been involved observations. When further intervalm. the AD was ur of activities offered of activity sheets for days of documental indicated R6 attend the AD stated he diactivity sheets faile participated, wande activity; the AD cordocumentation was R23 R23 was admitted including: demential disorder, and chroridisease (COPD) per The report further inhospice services or degeneration of the R23's quarterly Minassessment dated severely impaired of with locomotion on the services of the ser	then provided documentation was offered 5 times in mes in December 2015. about the preferred activities movies) documented on R6's cated being unaware of these in the current activity sheets obstantiate the activities each led, there was nothing documented indicating that R6 in activities during the days of viewed on 12/31/15, at 10:21 in a 10 10 70/15 and in rovided 5 days of viewed on 12/31/15, at 10:21 in 10 10 10 10 10 10 10 10 10 10 10 10 10	F 2				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245378	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	•	
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F 248	toilet use, and person R23's significant che 5/6/15, indicated accomportant to have be to read, very important to go when weather is go participate in religion R23's care plan lass resident was dependent and providing activities if (resident of room events. (2) participation in small interactions (3) EM player for individual ENVIRONMENTAL body language relative (Resident name) Repreferences included word search, TV and R23 was observed from 1:14 p.m. until A popcorn and moven p.m. in the activity ractivity held at 2:30 did not offer R23 thactivity. R23 was again obs 12/30/15, from 10:03 a.m. R23 was Cityside dayroom and moven p.m. in the activity ractivity held at 2:30 did not offer R23 thactivity.	_	F 248			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 248	eyes closed. The Aresident seated in word nurses station and attend church. R2 AD and the resident away and closed he area. NA-A then are to ask whether she nodded "yes". NA-opportunity to attend transporting her to attend this activity. At 11:08 a.m. R23 weyes closed while a process. She had to attend this activity. At 3:12 p.m. R23 we closed. A music activities dayroomember piano play to offer attendance. When interviewed on NA-B and NA-A conwith her morning catactivities, she oftendown. Both NA's of R23 attendance at R23 had been tearforceiving care and rather lie down. NA liked to color when	remained in the geri-chair with ND approached another w/c located near the Cityside asked whether she wanted to 3 opened her eyes when the t left for church but looked er eyes when they left the oproached R23 at 10:23 a.m. wanted to lay down. R23 A did not give her the d the church activity before her room. WES obse vec lying in be 1 with the chart in the opportunity was in the opportunity.	F 248	BED		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 248	When interviewed of AD stated R23's act daily Sunshine grouimplemented twice on Saturdays). AD does fine while atte sometimes needed service as would ground still expect R to participate in atte to located documer and 1:1's provided sheets indicated R2 times/weekly. AD p from 11/2/15 - 12/5/11/16/15 - 11/22/15 7 occasions during 11/12/15, 11/13/15, AD confirmed the 1 and did not identify response. Staff woreffectiveness of pla When interviewed of AD provided 10 day sheets for R23. The offered activities on unable to provide doffered in November activity sheets for C sheets did not inclust had participated or	on 12/30/15, at 1:40 p.m. the tivities included hair care, a up (sensory group) which is daily Monday-Friday and once stated the resident usually nding church service but to be removed from the et agitated. AD confirmed she 23 be offered the opportunity ending church. AD attempted nation of activities attended for R23. The 1:1 activity 23 was to have 1:1's three provided 1:1 documentation of the proof of	F 24			

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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F 248	Continued From pa	ge 23	F 2	48		
F 282 SS=D	PERSONS/PER CA The services provided be must be provided be accordance with eacare.	R' OES Y (JALII IEL AI E PLA) de or al ing d by the fac. it y qualified persons in ch resident's written plan of NT is not met as evidenced	F	ED	2/8/16	
	by: Based on observat review the facility fa related to activities reviewed for activitie Findings include: R6 When interviewed of 8:50 a.m. the direct R6 did not speak or further indicated sta	ion, interview and document iled to follow the plan of care for 2 of 3 (R6, R23) residents		The preparation of the following ple correction for this deficiency does a constitute and should not be interpleas an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was exposely because provisions of state federal law require it. Without wait foregoing statement, the facility state with respect to: 1. Resident #6 and Resident #23	not reted t by the led or lent of n lecuted and ving the ltes	

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F 282	diagnoses including disturbance, cognit chronic obstructive muscle weakness a facility diagnosis re R6's care plan for a indicated the reside but occasionally ne structuring leisure a wellness. Intervent plan: 1. CD player in roor resident's desire. 2. Recreation/Well exercise, listening the wrestling and war in sensory and 1:1 tim 3. EMOTIONAL: Condividual music endered and the program to individual cardio. The would work on puzzoneriod. On 12/29/15, R6 was 1:16 p.m. until 4:17 - At 1:16 p.m. until 4:17 - At 1:16 p.m. R6 was residents wheelcha west Cityside hallwas length of the hall st removed the transfithe dayroom area lettered.	the facility on 9/5/14, with g dementia without behavioral ive communication deficit, pulmonary disease (COPD), and difficulty walking per the port. activities dated 10/12/15, and was primarily independent eded some guidance with activities that promote ions identified on the care In piece pla music promote ionsic, vathing TV (engres) food related activities, i.e. offer ipod or CD player for joyment. Fourage participation in include group exercise and/or ne activity goal indicated R6 ales in day room by the review	F 2	care related to activities was reupdated to meet their individual needs. 2. All residents are assessed activity preferences upon admit quarterly and with a significant condition and care plans are upensure appropriate intervention implemented. All Residents has care plans reviewed to ensure of them are receiving appropriate activities. A special care plan inhosted by the Activities Directo conducted quarterly to ensure of them are receiving appropriate activities. A special care plan inhosted by the Activities Directo conducted quarterly to ensure in the long of	for their ssion, change in odated to s are ve had their that each te neeting will be hat or oper care will be embers of addition. Indition. Inditions care somplete s and then e terly QA&A arding any	

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F 282	R6 propelled himse dayroom. -At 1:27 a.m. nursing a round shaped semultiple-colored hobungy type cord. The stretched and manitem, talking out louded the item, he did he attempt to manifold the area at R6. -At 1:34 p.m. a staff the middle of the dayresident. R6 continuous ensory object remained at the tablegan to propel the attempt to him earlier was not touching not though he appeared time, a popcorn aring the activity room. -At 2:07 p.m. it was on edge of bed with sensory item remained at that R6 interested in this second that R6 interested the R6 interested that R6 inte	and assistant (NA)-A brought R6 insory item which consisted of a low tubes held together with a mis enabled the object to be applied. R6 accepted the add constantly. Although R6 indicates or pull the sensory item. After the item was delivered to a short time and then a whole a short time and then a whole a short time and then a whole and the delivered to a delivered lying in bed on shoes on. The sensory item was placed on his legs. R6 or handling the item even d to be wide awake. At this and movie activity was occurring a feet dangling down; the ned on resident's lap. It was a was not touching nor	F 2	SED		

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F 282	sensory object was music was playing in the bed attempting shoe. R6 had a newere present in the Coffee social and wheld in the dining row attending to the net continued to sit on a remove the laces fr R6 remained seate onto the unlaces left entered the room a medication aide (TN and asked whether shoe". NA-C aske supposed to have that if NA-C could grould transfer him in about it. On 12/29/seated on the side without laces. R6 ashoe. The Wellness schedule for 4:00 pseated on edge of the shoe. This active 2:30 p.m. (almost 2). R6 was not offered activities during the observation on 12/2 not followed as writ sensory object thou	no longer visualized. No n the room. emained seated at the edge of to pull the laces from his left bulizer mask on and no staff room during this observation. For games activities were from at this time. 150 p.m., LPN-D in R6's room bulizer machine while R6 edge of bed attempting to om his left shoe. At 2:56 p.m. doi: 100 p.m. NC in greated R. I mained M.) -A and ele ered the room has sull working on his domain the shoe. TMA-A responded the tit laced and on R6, they into his chair and not worry 15, at 3:57 p.m. R6 remained of bed, holding his left shoe opeared to be examining the segroup was on the activity into the left shoe of the replace the laces back in ity had been continuous since	F 282				

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F 282	with R6. It was observed on church activity was room. R6 independ the west hallway but the administrator reback down the direentered the dayroo perimeter of the arwindow and then witank. R6 propelled east hallway and reuntil 10:30 a.m. LP east hallway to a tan No verbal commun noted between staf offered/assisted to throughout the note interact with the result of the commun thank. R6 propelled east hallway to a tan No verbal commun noted between staf offered/assisted to throughout the note interact with the result of the commun thank. R6 propelled east hallway to a tan No verbal commun noted between staf offered/assisted to throughout the note interact with the result of the commun thank. R6 propelled east hallway to a tan No verbal commun noted between staf offered/assisted to throughout the note interact with the result of the community of th	12/30/15, at 10:04 a.m. a conducted in the activity lently propelled himself down at once R6 turned the corned, edirected and propelled him ction of the hallway. R6 then m, propelling self around the ea, pausing to look out the atched the activity in the fish self toward the direction of the emained seated near this area N-C then moved R6 from the lab local dir modalyrom. ic tion no increation wis final a. R6 was not the church ac ivity at anytoned observations not und standard.	F 2	SED		

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F 282	snack in the main a finished his snack, front area of the dir table. No activity si R6 until they assiste towards the direction. When interviewed a AD stated R6 is ver and is scheduled for further indicated that were scheduled for stated staff will also well as the men's galiant to well as the men's galiant were greatly. When questioned a (wrestling and war care plan, she indiction preferences. When were reviewed to sure sident had attend highlighted and/or chad been involved in observations. When further interval. The AD provides activity sheets which activity sheet dated resident was offere	ge 28 er residents were served their area. At 2:41 p.m. when R6 propelled himself around the aing room near his designated raff were noted to interact with red out of the dining room on of his room at 2:44 p.m. on 12/30/15, at 12:41 p.m. the ry "antsy" r/t group activities or in-room programming. AD at 2 in-room activity programs 20 minutes/day. AD also offer coffee social time as a recept activity and the current activity sheets and being unaware of these on the current activity sheets abstantiate the activities each ed, there was nothing documented indicating that R6 on activities during the days of the iewed on 12/31/15, at 10:21 and 10 days of December 2015 hindicated R6 was offered at 10 days. AD stated the 12/21/15, indicated the did the exercise activity. AD to R6 during the activity and	F 2	SED		
	provide documenta November 2015 an sheets for October	However, the AD was unable to tion of activities offered in d provided 5 days of activity 2015. It was confirmed the of implemented as written.				

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F 282	including: demential disorder, and chrord disease (COPD) per The report further in hospice services or degeneration of the R23's care plan lass resident was deper and providing activistimulation due to discluded: (1) "1 to activities if [residen of room events. (2 participation in small interactions (3) EM player for individual ENVIRONMENTAL body language related [Resident name] Repreferences included word search, TV ar R23 was observed from 1:14 p.m. untited A popcorn and mosp.m. in the activity lactivity held at 2:30 did not offer R23 thactivity. R23 was again obsisted as a same as a same activity. R23 was again obsisted as a same activity.	on 1/6/15 with diagnoses a, paranoid personality, mood nic obstructive pulmonary er the facility diagnosis report. dentified R23 was admitted to a 5/15/15 due to senile	F 282	BED			

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At 10 eyes reside nurse attendad away area. to asl nodde opport trans. At 11 eyes proce to attendad to attendad away area. At 3:1 close the Comemit to off. When NA-B with hactivity down R23 area. R23 hactivity and the with hactivity down R23 area.	closed. The Ament seated in the station and dischurch. R2 and the resider and closed has whether she at the seated in the seated	remained in the geri-chair with AD approached another w/c located near the Cityside asked whether she wanted to 23 opened her eyes when the at left for church but looked er eyes when they left the approached R23 at 10:23 a.m. a wanted to lay down; R23 and a did not give her the ad the church activity before her room.	F 282			

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F 282 F 309 SS=G	expect R23 be offer participate in attend located documentar 1:1's provided for R indicated R23 was attimes/weekly. AD provided 11/2/15 - 12/5/11/16/15 - 11/22/15/7 occasions during 11/12/15, 11/13/15, When interviewed of AD provided 10 day sheets for 23. The offered activities on unable to provide doffered in November activity sheets for C sheets did not inclused participated or confirmed the chart incomplete. The plaimplemented as write 483.25 PROVIDE OF HIGHEST WELL BURGHEST WELL BURG	confirmed she would still red the opportunity to ling church. AD attempted to tion of activities attended and 123. The 1:1 activity sheets to have 1:1's three provided 1:1 documentation 15 (minus the week of 15); R23 was provided a 1:1 on this period (11/5/15, 11/7/15, 11/27/15, 12/4/15, 12/7/15). In 12/31/15, at 10:21 a.m. the residence of the 0 cays. AD was a first our activity of the 10 cays. AD was no first of activity; AD ting of activities was an of care was not itten. CARE/SERVICES FOR		SED 309		2/8/16
	by:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 309	facility failed to provand services for 2 or reviewed who had be resulted in actual haprolonged discomfor related to delayed in transfer to an inpation obstruction. In add provide appropriate dementia care for 1 who had demential speak/understand E. Findings include: R46's discharge or dated 9/17/15, iden improving with order occupational therape. R46's physician's producted diagnoses lumbar region, seps 1 midicated diagnoses lumbar region midicated diagnoses lumbar regi	and document review, the vide adequate nursing care of 4 residents (R46, R21) been hospitalized. This arm for R46, who experienced ort, dehydration and vomiting nursing assessment and ent facility for a small bowel ition, the facility failed to interventions related to of 1 resident (R6) reviewed and could not english. The facility failed to of 1 resident (R6) reviewed and could not english. The facility failed to of 1 resident (R6) reviewed and could not english. The facility failed to of 1 resident (R6) reviewed and could not english. The facility failed to of 1 resident (R6) reviewed and could not english. The facility failed to of 1 resident (R6) reviewed and could not english. The facility failed to of 1 resident for physical and the failed of 1 resident for physical and the failed of 1 resident field a tis of the colon. The facility failed to of 1 resident field a tis of the colon. The facility failed to of 1 resident field a tis of the colon. The facility failed to of 1 resident field a tis of the colon. The facility failed to of 1 resident field a tis of the colon. The facility failed to of 1 resident field a tis of the colon. The facility failed to of 1 resident field a tis of the colon. The facility failed to of 1 resident field a tis of the colon. The facility failed to of 1 resident field a tis of the colon. The facility failed to of 1 resident field to of 1 resident field	F3	809	The preparation of the following placorrection for this deficiency does in constitute and should not be interporant an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was exsolely because provisions of state a federal law require it. Without waive foregoing statement, the facility state with respect to: 1. Resident #46 is deceased. The facility found a more appropriate place with respect to: 1. Resident #46 is deceased. The facility found a more appropriate place with respect to has mong speakings aff. This resident with the facility and be pit a commended by nis primary physician. 2. All residents have been reviewed ensure that any non-English speak someone in the facility who speaks language. All residents have been reviewed for any significant change condition and need to notify the physician domitication per phone call and DNS. 3. Education to licensed staff will completed by 2-3-16 on significant change in resident condition, physic notification with any change in resident condition and the importance of has someone available to speak the lar of all non-English speaking resident. Nurses will notify the physician immediately (in a timely manner) we residents have a significant change condition and they will also notify the physician immediately (in a timely manner) we residents have a significant change condition and they will also notify the physician immediately (in a timely manner) we residents have a significant change condition and they will also notify the physician immediately (in a timely manner) we residents have a significant change condition and they will also notify the physician immediately (in a timely manner) we residents have a significant change condition and they will also notify the physician immediately (in a timely manner) we residents have a significant change condition and they will also notify the physician in the physician in the physician in the physician	not reted by the ed or ent of necuted and ing the tes ne cility sident laced setting ed to er has their ein vsician be cian dent ving nguage ts. hen ein	

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F 309	2:00 a.m. on 9/26/1 licensed practical in the medication admadministered on 9/2 the medication had since supper. No feffectiveness was dentry dated 9/26/15 had received anoth stomach and emes listed as had anoth the other doses admesults documented. A nursing progress 9/25/15 at 8:30 a.m. and complaints of rindicated R46 had along with Thorazir after his morning in had experienced a the bed and himsel anything for breakforange juice that had A nursing progress on 9/25/15, at 1:39 large emesis, and the was not feeling well hiccups had subsidistanted again. Doc received Maalox ar medication used for another small emedication used for anothe	date, as well as one dose at 5. Notations documented by Jurse (LPN)-A, on the back of ministration record for a dose 25/15, at 2:00 a.m. indicated been given for stomach upset ollow up assessment for completed. A subsequent 5, at 2:00 am. indicated R46 er dose of Maalox for an upset is; the follow up result was er emesis at 4 a.m. None of ministered had follow up d. In the writin I / LPN-F c and the projection of the line we are the projection of the large projectile emesis all over f, and had refused to eat ast, stating he had consumed	F3	309	Director of Nursing. They will no louse fax to communicate these series issues regarding residents. Prior to admission the facility will ensure this someone available who speaks thanguage of any non-English speaks. The DNS or designee will communities weekly for 4 weeks and wee 2 months to ensure that the facilities guideline is being followed correctly 6. The data collected will be reviewed/discussed at the quarterly meeting. At this time the QA&A committee will make the decis of the communities. The INS is resonable for this PC Completion Date. 2-6-16	ous o at there the ker. plete 2 kly for es y. y QA&A	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (2)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245378	B. WING			12/3	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			20	TREET ADDRESS, CITY, STATE, ZIP CODE DO EAST NINTH AVENUE AMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	p.m. per LPN-F indimost of the evening hiccups were better but that R46 had be feel right and that w to gag. R46 had easips of water. Additindicated a fax (face medical doctor (MD condition including temperature at 99.5 feeling chilly. A nursing progress p.m. per LPN-F indifeeling well, and ha emesis twice on the appear to have a febeen given to help witamins had been In A nursing progress at 1:56 a.m. indicated distended, his bowe and he had been	note dated 9/25/15, at 6:00 cated R46 had stayed in bed p. The note indicated R46's over the early evening hours been stated his tummy still didn't whenever he moved he began atten Jell-O for supper and had conally, the documentation simile) had been sent to color with an update on R46's that R46 had an elevated of degrees F and complained of the teat of Jell-O for supper and had conally, the documentation simile had been sent to color with an update on R46's that R46 had an elevated of degrees F and complained of the teat of Jell-O for supper and sent to color with hiccups and R46's held due to emesis. Interpolation of Jell-O for supper and had not color with hiccups and R46's held due to emesis. Interpolation of Jell-O for supper and had not color with hiccups and R46's held due to emesis. Interpolation of Jell-O for supper and had not color with hiccups and R46's held due to emesis. Interpolation of Jell-O for supper and had not color of the proper and had not color of	F3	809	SED		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	` '	E SURVEY PLETED	
		245378	B. WING		12/	31/2015	
	PROVIDER OR SUPPLIER VIEW MANOR HCC		STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 309	9/26/15, at 9:57 a.r further emesis of g of BM looking in it. an acute care hosp order was received emergency room (I indicated R46's data agreed to meet him facility at 8:45 a.m. A faxed physician's present in R46's reorder to transfer perhospital. An additional nursing 9/26/15, at 2:06 p.r admitted to the acutiagnoses of bowe surgery. A faxed physician's p.m. from the facilitidentified that R46 experienced several throughout the day drink. R46 complained had not been signed days later, when the responded with a stelephone order to Please do NOT fax need attn [attention [physician] - today faxing for responses.	note entered by LPN-B, dated in. indicated R46 had two reenish liquid thick with pieces. In addition, the note indicated bital had been called and an it to transfer R46 to their ER) via ambulance. The note ughter was updated and had in at the hospital. R46 left the indicated of the indicated of the indicated of the physician of an armoulance to the acute care in the care hospital with a lobstruction, and would need in order sent on 9/25/15, at 6:05 by to R46's primary physician had emesis since 8:30 a.m., all rounds of hiccups and had been unable to eat or ined of feeling weak. The fax and off until on 9/28/15, three is enurse practitioner (NP)-A tatement including, "Noting transfer to ER on 9/26/15. In regard to situations that in that day. This will be sent to 9/28/15. Please review the exprocedure. Thx [Thanks]."	F 309	BED			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		E SURVEY PLETED
		245378	B. WING		12/:	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	been uncomfortable with dried brown m. The ER note furthe was firm and diffus with no appreciable 1800 milliliters (ml) drained from R46's a nasogastric tube. normal saline intrave physician's note included dehydrated and diagnoses of small dehydration. The ER registered 9/26/15, at 11:17 a. he'd been vomiting emesis was now brownited three times the ER and the von brown liquid running abdomen was very and the abdomen vomplained of abdorate the pain. R46 nasogastric tube for fluid output after whother. R46 was allowed what ever we have The hospital dischaindicated R46 had to correct the small developed subsequanticoagulation is surgery. The ileus	essed when examined, had e, and had dry oral mucous aterial on the tongue and lips. I indicated R46's abdomen ely distended, mildly tender bowel sounds. In addition, of brown liquid had been stomach after the insertion of R46 had received 2000 ml of venous for hydration. The ER dicated R46 had appeared not verified the admitting bowel obstruction and severe in the rated: 140 rad stated for the rated: 140 rad stated in the ambulance enroute to nit was described as dark gout of his mouth. R46's firm, with no bowel sounds was distended. R46 ominal pain but was unable to had his stomach drained via a raten minutes with 1400 mL of nich R46 stated he felt much ert and "states we should do to do. Is comfortable now."	F 309	BED		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
		245378	B. WING		12/:	31/2015
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F 309	During interview on director of nursing (expected staff to commediately with the specially when the BM-type material and During interview on nursing home's head coordinator/nursing LPN-B was not well hospital intensive of interview. The HIM pool nursing staff. During interview on acting administrator the time of the incidence	12/29/15, at 3:07 p.m. the (DON) verified she would have ontact the on-call doctor e urgent clinical issues, e resident was vomiting and not feeling better. 12/29/15, at 3:32 p.m. the alth information scheduler (HIM) stated I and was currently in a are unit, unavailable for value PN mad beta 1 a 12/29/1 at 3:45 p.m. the r, who had been the DON at dent stated she'd thought dicated he was admitted to the el obstruction, but that it had be a narrowed bowel. The unable to recall specifics isode of illness; however, ave expected staff to call and/or primary physician ins that were urgent. The dishe would have expected the ital signs, bowel movement of fever status while conducting itent. The administrator stated was a good nurse and trusted further verified LPN-A worked	F 309	SED		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	45 FOR MEDICARE	& MEDICAID SERVICES			OMB NO). 0938-039 I
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE	(X5) COMPLETION DATE
F 309	been unaware a fas stated she'd worked prior and was aware complaints of not feel She was aware R4been eating well, an administered Maalox first time she admir LPN-A verified R46 like stool but there abdomen had also LPN-A was unawar complained of pain subsequently vomit later in her shift (and she'd become concompagerwork for a hornot call the RN on the concern. LPN-along the paperworn urse, LPN-B, who on 9/26/25. LPN-A an assessment to for During the interview there had been a high she had noted whe pass along to the doministral notified the physicial symptoms, and that	ng R46's emesis, but had a had been sent. LPN-A d with R46 at least one time e R46's vomiting and seling well was new for R46. So had thrown up and had not had subsequently by during the night. LPN-A had helped somewhat the histered it (around 2:00 a.m.). had emesis of what looked was no odor. She verified his seemed a little distended. The whether R46 had helped somewhat his seemed a little distended. The whether R46 had helped somewhat his small bower. LPN-A had to fill out all the transfer spital discharge; however, did had her concern to the day arrived on duty at 6:00 a.m. stated she'd told LPN-B to do hollow up on R46's condition. When the paperwork to any shift personnel. Interview on 12/30/15, at 9:12 tor stated LPN-A should have an sooner about R46's the had not been aware elay in his nursing care and	F3			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245378	B. WING _	·····	12	2/31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP COL 200 EAST NINTH AVENUE LAMBERTON, MN 56152		
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F 309	medical director way would have expected they filled out the patch anyway, prompt medical confortable. The effect of delayed manyway, prompt medical doctor (ME) stated to R46's medical doctor (ME) stated he would have called the clinic and R46 began vomiting stated faxing medical p.m. was inappropring the end of the delay in after his symptoms made some "deprehospital transfer on were a "sidebar" and issue. MD-A confirmation of the ER. It womiting brown stuff you are seen." The facility's policy SBAR last revised anotification of the pasymptom, sign or a sudden in onset, a	ge 39 12/30/15, at 2:11 p.m. the is interviewed and stated she de nursing staff to call when aperwork to transfer R46 to nedical director stated have subsequently expired edical care would have made the medical director stated the edical care/interventions edical outcome was difficult to snot his usual physician. 12/31/15, at 9:27 a.m. 13/31/15, at 9:27 a.m. 14/31/15, at 9:27 a.m. 15/31/15, at 9:27 a.m. 16/31/15, at 9:27 a.m. 17/31/15, at 9:27 a.m. 18/31/15, at 9:27 a.m. 19/31/15, at 9:27 a.m. 10/31/15, but the o-ca physician was edical attention began. MD-A stated R46 had seed about the potential for en R46 arrived at the hospital, receipt of medical attention began. MD-A stated R46 had seed "comments prior to the 9/26/15, but those comments at were not relevant to this med R46 would have been the had been examined MD-A stated, "when you are fight it is probably a good idea if entitled Change in Condition and S/15, indicated immediate hysician was required for any parent discomfort that was marked change (i.e. more or usual signs and symptoms	F 30			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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F 309	prescribed. The posection related to a immediate notification required when there of marked tenderned (gastrointestinal) blood Review of R21's Marked (MAR) date that blood sugar (Barred (Bar	by measures already blicy further indicated in a bdominal distension that ion of the physician was a was rapid onset, or presence ess, fever, vomiting or Gleeding. Idedication Administration and December 2015, identified S) readings were monitored ay. Between the dates of 12/1 are 44 blood sugar (BS) levels ented as 400 milligrams (mg)/bove, with 25 of those are readingly shown as a readingly one esider is lood sugars at readingly look that pare which	F 30	SED		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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F 309	how the resident fe BS-which she ident 500's". On 12/30/15, at 2:3	ige 41 would notify the MD related to It and if there was a high ified as "way above 400's- 66 p.m. LPN-D stated she of if she obtained a BS result	F 3	.09		
	above 600 mg/dL. 12/29/15, the support mg/dL and the MD further stated R21 fabove 400 mg/dL aread to give 6 units was greater than 35 when the glucomet of a BS over 600 m the nurse on call at reading.	LPN-D confirmed on er BS check for R21 was 521 was not updated. LPN-D frequently has BS readings and the facility standing orders of regular insulin if the BS 50 mg/dL. LPN-D indicated er cau light was the resulting JL and the would tele hone the sucception of the		SED		
	diabetic educator in reports of R21's BS the clinic has a protadjustments and the were based upon. stated R21 had a hand nursing staff we medical provider or related to changes educator further incomparameters had be recently discharged 12/5/15. She indicates	12/30/15, at 2:57 p.m. the dicated she received weekly be results. She further stated tocol for diabetic medication is was what insulin changes. The diabetic educator further istory of being a brittle diabetic ere supposed to call the neall and/or the triage nurse in status. The diabetic dicated she thought BS en identified when R21 was a from the the hospital on ated the parameters would need by the discharging MD.				
	and RN-C stated the for reporting BS real	12/30/15, at 3:12 p.m. RN-B here were facility parameters adings. They referenced the her facility's standing orders				

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F 309	and stated that wor followed unless ind written. RN-B indic symptomatic she w based on the stand and RN-C indicated Change in Conditio reporting of BS rear RN-B stated, "we weveryone is aware of the stated of the stated she had be a months at the faction area, wear gloves, resident had ordered specific insulin order specific insulin ordered SS dose at then recheck in the whether the BS was stated she would put this instance as this fluctuations. LPN-E have specific ordered she would do. On 12/31/15, at 9:00 the facility's medicar resident would have from the hospital for physician stated R2 before admission to history of blood sugthat the resident was and stated R2 before admission to history of blood sugthat the resident was and stated R2 before admission to history of blood sugthat the resident was and stated R2 before admission to history of blood sugthat the resident was and stated R2 before admission to history of blood sugthat the resident was and stated R2 before admission to history of blood sugthat the resident was and stated R2 before admission to history of blood sugthat the resident was and stated R2 before admission to history of blood sugthat the resident was and stated R2 before admission to history of blood sugthat the resident was and stated R2 before a dmission to history of blood sugthat the resident was and stated R2 before a dmission to history of blood sugthat the resident was and stated R2 before a dmission to history of blood sugthat the resident was and stated R2 before a dmission to history of blood sugthat the resident was and stated R2 before a dmission to history of blood sugthat the resident was and stated R2 before a dmission to history of blood sugthat the resident was and stated R2 before a dmission to history of blood sugthat the resident was and stated R2 before a dmission to history of blood sugthat the resident was an and stated R2 before a dmission to history of blood sugthat the resident was an	ild be the practice they ividualized orders were ated if a resident was ould notify the physician ing order instructions. RN -B I they were not aware of the n policy related to immediate dings above 430 mg/DL. ill have to make certain	F 309	SED		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY IPLETED
		245378	B. WING		12/	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	for an elevated blood provide specific ord required to recheck results. She stated, 'hi' because they had blood sugar is below to initiate the hypogindicated she would and/or on-call staff were outside range. When interviewed director of nursing (2015 documentation indicated she was used for the staff to notify the attempt of the staff in accordance when to Report to the staff in accordance. The facility's policy notification for blood Change in Condition MD/nurse practition last revised 3/15, in than 430 mg/dL (or diabetic patients us be immediately representationer (NP)." When interviewed to 8:50 a.m. the DON understand or be uncommunicated using expressions.	she'd received a telephone call od sugar level she could ers as to when staff were the BS and call back the "they call if the meter reads are nothing to base it off. If the w 70 mg/dL staff would need lycemia protocol." She further dexpect staff to notify the clinic to update on BS readings that the DON) reviewed the December of the DON reviewed the December of the DON is the wide fluctuation of the MD/NP/PA policy.	F 309	BED		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
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F 309	with a cognitive con R6's annual MDS a revealed the reside cognition with daily intruded on the priviple behavior towards of not directed toward than daily. The MD extensive assistant locomotion on/off upersonal hygiene. The resident was able to comple preference portion on R6's care plan date falls related to (r/t) I weakness, gait/bala incontinence, hearing impaired cognition, needs. Intervention meet needs, encouexercise, physical a improved mobility, at three times daily, rewall or objects, use The care plan further problem r/t hearing Interventions including resident/family concommunication difficulties were unable to comthe progression of the effectiveness of corassistive devices.	without behavioral disturbance nmunication deficit. ssessment dated 10/9/15, nt had severely impaired wandering that significantly acy of others, physical thers 1-3 days, other behavior is others 4-6 days but less as also indicated R6 required the with bed mobility, transfer, nit, dressing, toilet use, and the MDS further indicated nor family/significant other the model by a convity of he as assent. If the MDS further indicated nor family/significant other the model by a convity of he as assent. If the MDS further indicated arise for nistory of halls, generalized ance problems, bladdering and vision impairments, and difficulty communicating in sincluded: anticipate and rage activities that promoted activity for strengthening and ambulate with staff in hallway adirect when wheeling close to distraction when restless. For identified a communication deficit and head injury.	F 309	BED		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245378	B. WING		12	/31/2015	
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP (200 EAST NINTH AVENUE LAMBERTON, MN 56152	· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 309	by two staff with a wheelchair (w/c) be "Cityside" hallway. while walking and a understood, spoke turn talked to the relength of the hall, the tothe dayroom in fine then propelled hims his w/c. -At 1:27 p.m. NA-A that was rounded in multiple-colored hotype cord enabling manipulated. R6 a loud constantly and the item but did not attempted to manipulated. R6 continus and the middle of the diresident. R6 continus ensory object reminteraction with staremained at the tablegan to propel him dayroom. -At 1:44 p.m. R6 stantage of the direction with staremained at the tablegan to propel him dayroom. -At 1:52 p.m. R6 property of the drinking four the drinking four the direction with grown the area from.	was observed being ambulated third pushing the resident's whind him down the west. The resident was cooperative although could not be and smiled to the staff, who in esident. After walking the he resident was assisted back ront of the television (TV). R6 self throughout the dayroom in a brought R6 a sensory item of the properties of the substantial to t	F3				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245378	B. WING		12/31/2015	
	PROVIDER OR SUPPLIER VIEW MANOR HCC		:	STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	,	
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F 309	approached R6 and mug with water the mug. R6 accepted to mumble out loud west hallway toward. Once R6 made it to intercepted the resiroom. -At 2:00 p.m., R6 was covers without shoer resident was holdinglegs. R6 eyes were resident was holdinglegs. R6 e	atain. A staff member d assisted him with filling the n replaced the cover on the the water mug then continued and propel himself down the ds the administrative offices. The end of the hallway, staff dent and returned him to his as lying in bed on top of es. A sensory item the g earlier was on the resident's wide open. The same of the edge of the in and the sensory object. The sensory object.	F 309	SED		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	K2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
		245378	B. WING		12/	31/2015	
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 309	begin at 4:00 p.m. of was still on the edg re-lace his shoe. To continuous since 2: R6 was not approasignificant staff to rethe three hour cont 12/29/15. The residobject though staff could be used or sp. Staff provided minic continually redirected eventually put into be wide awake. R6 was observed of following times: At 7:50 a.m. R6 we the corner of the dindependently. The wall on two sides. Fresidents as he factory table. Staff handed shaped sensory ob when manipulated. Without further interbehind him on the staff to propel himself paths the dining room to the LPN-C was standing understood, he voo R6 he had already resident back to his	ellness group was scheduled to On 12/29/15, at 4:17 p.m. R6 e of the bed, attempting to his activity had been 30 p.m. or nearly two hours. It ched and/or involved in any esident communication during inuous observation on dent was handed a sensory failed to model how object bend time with the resident. In all interaction with R6 and ed him to his bedroom and of the child had be as seated alone at a table in hing room eating breakfast estable was pushed flush to the R6's back was to the other	F 309	BED			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		E SURVEY IPLETED
		245378	B. WING		12/	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE
F 309	The bedding was p was holding onto thup in bed. -At 8:25 a.m. R6 was bed and the w/c was	age 48 pillow without a pillowcase. iled at the end of the bed. R6 are grab bar, attempting to sit as seated at the edge of the as positioned next to bed with R6's tennis shoes were	F 309			
	located on the seat was wearing shoes the side of the room surveyor alerted the walking by to quest of independent ambatated R6 did some redirected R6 to his administrator asked oxygen (O2) as he	of the w/c. At 8:36 a.m. R6, and was ambulating along as he felt the wall. The eadministrator who was ion whether R6 was capable oulation. The administrator etimes a bullion, and so heelch ir. The down ether remeded is wis hearly k eathing. The anasal cannula and the	15	SED		
	propelled himself frentered another resthe hall. Upon enter	okg)-A intervened and				
	the activity room. R himself down the w the corner, the adm propelled him back hallway. R6 then er himself around the to look out the wind fish tank. R6 prope direction of the eas	urch activity was conducted in 6 independently propelled rest hallway but once he turned ninistrator redirected and down the direction of the ntered the dayroom, propelling perimeter of the area, pausing low and watched the fish in the lled himself toward the thallway and remained seated in LPN-C then moved R6 from				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245378	B. WING		12	/31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
F 309	the east hallway to dayroom. No verbainteraction was noted. At 11:07 a.m. R6 was identified or planned intervention seated in w/c in Citystation when the act dayroom, said "Hi" on the TV and walk remained seated at dining room with his residents. -At 2:16 p.m. NA-B R6 to ambulate, host stand when prompt seconds. The transstaff left the resider. -At 2:35 p.m. R6 was the men's group act area of the dining rowhile located in the room, partitioned of R6 was offered his routinely had been from the other residence snacks in the main when R6 finished he around the front are designated table. No he was assisted out the direction of his residence intervention of his residence intervention of his residence intervention of his residence intervention.	a table located in the al communication nor ed between staff and R6. Vas seated in w/c in dayroom a wellness activity in process on the plan of care as an in. At 11:27 a.m. R6 was vide dayroom near nurses tivity director (AD) entered the to R6, turned up the volume ed away. At 11:48 a.m. R6 the table in the corner of the shack away from the other a unx -A at implied to a sis we ver, the relident did no eu for approximately 30 offer belt was removed and the oth. as in the dining room where tivity was held in the main from. R6 was served a snack front area of the main dining f by a wall with two openings. snack at the table where he served meals, alone and away lents who were served their dining area. At 2:41 p.m. is snack, propelled himself as of the dining room near his to staff interacted with R6 until to f the dining room towards froom at 2:44 p.m. When 0/15, at 12:41 p.m. the AD	F3	SED		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245378	B. WING		12/	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	TMA-A indicated the communicate with the attempted any alter unfair to R6. TMA-approximately monitive well icensed social work they were unsure where able to talk to his fareally attempting. When interviewed of the contact his family attempting. When interviewed of DON confirmed the returned to his room wandered. The DOI informed the reside a bare mattress, line bed, and no pillowed agreed staffs' interval appropriate interver 483.25(i) MAINTAIN UNLESS UNAVOID Based on a resident assessment, the fair resident - (1) Maintains accept status, such as bod unless the resident'demonstrates that the status in the status is the status of the st	on 12/20/15, at 3:36 p.m. bey were unable to he resident and had not native method, and said it was A said R6's family visited thly. on 12/31/15, at 8:50 a.m. the ker (LSW) and DON stated thether R6 would have been mily on the telephone. The never attempted to assist him at the said it would be worth to 1:2/31/5, at 1:25 p.m. the lose ruld native been may the said it would be worth to 1:2/31/5, at 1:25 p.m. the lose ruld native been may the said it would be worth to 1:3 d when he lose ruld native been may the pushed to the end of the ase on the pillow. The DON rentions and/or lack of attions were concerning. IN NUTRITION STATUS DABLE "It's comprehensive cility must ensure that a stable parameters of nutritional by weight and protein levels, is clinical condition his is not possible; and apeutic diet when there is a	F 309	BED		2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	245378	B. WING		12/3	1/2015
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW MANOR HCC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE AMBERTON, MN 56152		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325 Continued From page	e 51	F 325			
by: Based on observation review, the facility fail were implemented to loss for 1 of 3 resider nutritional status. Findings include: R28's physician order revealed diagnoses in kidney disease and of the quarterly Minimum 12/11/15 revealed R2 the past month or 10 residents current weigneating problems. The had experienced a wearing problems. Review of the most of R28 as having potent to dementia and decreated an	a Se (MDS), day d 3 had we tht loss of 5 % in which in the past o months. The ght at 150#. No chewing or a MDS further identified R28 eight loss of 20# pound (lb) as dated 9/16/15, of a current care plan identified tial nutritional problems due reased cognition. Include: staff assist to set up nitor the residents intake and a the physician, monitor the direport to the physician any is and allow the resident time.		The preparation of the following placorrection for this deficiency does in constitute and should not be interplated as an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was existed solely because provisions of state as federal law require it. Without waith require it. Without waith espect to: I esquent # 3 had I is diet revies according to his currical needs. Residents showing weight loss residents were reviewed for weight had their dietary needs reviewed by licensed dietician and any changes that were necessary to improve the clinical profile with regard to nutrition. Education will be completed on at an all staff meeting to ensure that interventions are implemented to posignificant weight loss. The Interdisciplinary Team will weekly to review and discuss weigh and interventions for nutritional semantic methods are interventional concern. MDS Coordinator will do an audit we for 2 months to ensure that the nutron concerns of residents are being follows. The data collected will be	not reted by the ed or ent of necuted and ing the tes wed by lade (all loss) / a made eir on. 1 2-5-16 at revent meet nt loss vices. It new is. The reekly ritional	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	` /	(X3) DATE SURVEY COMPLETED	
		245378	B. WING		12/:	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE AMBERTON, MN 56152	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 325	Review of R28 nutr 10/14/15 indicates 170#. The resident his meals and is on or swallowing problem or swallowing interview with 12/29/15 at 2:00 p.10 of who was responsible to problem or swallowing	itional assessment dated the residents weight was at eats an average 75-100% of a regular diet with no chewing ems. ni nutritional assessment has significant change ents food intakes are stable ed. The resident is showing a nathe past 3 months and is at an the past 3 months and is at an the past 3 months and is at and to causal factors nor do to the weight loss. Let ry intal as are the previous of the second food in the past 3 months and is at an to causal factors nor do to the weight loss. Let ry intal as are the previous of the past of the past of the previous of the past of the	F 325	meeting. At this time the QA&A committee will make the decision/recommendation regardifollow-up studies. The Dietary Manager and MDS Coordinator will be responsible fo POC. Completion Date: 2-8-16		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245378	B. WING			12/:	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			20	TREET ADDRESS, CITY, STATE, ZIP CODE DO EAST NINTH AVENUE AMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465 SS=D	12/30/15, at 8:00 a. resident his meal. This meal but did not the resident received diet with no chewing. During interview with at 8:00 a.m. she con R28's significant we nursing staff indicated probably due to his more assistance with included she did not intervention nor recoloss due to the residence with the residence of the	s of R28 eating breakfast on m. staff were feeding the The resident consumed 90% of a participate in the process. Wed a regular mechanical soft of or swallowing problems. The the facility RD on 12/30/15, and the facility RD on 12/30/15, and the same of eight loss and stated the red R28's weight loss was dementia and he required the eating. The RD further the sound the reduced the same and the required to a line of the R28's veight loss. The RD further the sound the reduced about a resident all within their BMI, but may and month. When further did confirm R28's significant have been addressed by the lors and follow up	F 3		DEFICIENCY)		2/8/16
	by: Based on observat	NT is not met as evidenced ion and interview the facility f 5 rooms (Room 109, R6)			The preparation of the following place correction for this deficiency does r		

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 A. BUILDING				SURVEY PLETED
	245378	B. WING			12/3	31/2015
			20	00 EAST NINTH AVENUE		
				AMBERTON, MN 56152		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
·	_	F 4	65		اد مغمد	
				as an admission nor an agreement	by the	
Findings include:				conclusions set forth in the statement	ent of	
on 12/31/15, at 8:30 hole approximately sheetrock at the basis adjacent to the turburing observation at 8:35 a.m. the mathe damaged wall in	and interview on 12/31/2015, intenance director confirmed in the bathroom of room 109.			prepared for this deficiency was ex solely because provisions of state a federal law require it. Without waiv foregoing statement, the facility sta with respect to: 1. Resident #6 bathroom wall wa repaired by maintenance. 2. All resident s rooms were obs	ecuted and ring the tes s	
damaged the reside tub room was adjace maintenance director size hole in the wall dispenser and agre- did not create a hor maintenance director policy/procedure but request on the clipb	er 's wall He indicated he is a 16's burnoum. The policy furthe cor irmed a quality below the toner paper ed the areas in the bathroom nelike environment. The por could not provide a t indicated staff would fill out a poard when there was a			'aff reeing o 2-5-16 Staff wer it or red to not y the relational and they see that are damaged and need repair maintenance was in-serviced on the toprovide repairs for the aesthetic enjoyment of the residents. 4. The Maintenance director will of weekly walk through checking for of in rooms for 1 month and then birther for 2 months and then monthly to e that the facility does not have any will need of repair. 5. The data collected will be reviewed/discussed at the quarterly meeting. At this time the QA&A committee will make the decision/recommendation regarding follow-up studies. The Maintenance Director and	e things and e need do a lamage nonthly nsure valls in QA&A	
	PROVIDER OR SUPPLIER VIEW MANOR HCC SUMMARY STAY (EACH DEFICIENCY REGULATORY OR LS) Continued From pareviewed with floor of sheet rock that was Findings include: During observation on 12/31/15, at 8:30 hole approximately sheetrock at the basis adjacent to the turb. During observation at 8:35 a.m. the mathe damaged wall in He stated, "tub has damaged the reside tub room was adjace maintenance directed size hole in the wall dispenser and agredid not create a hormaintenance directed policy/procedure burequest on the clipber and appropriate to the clipber and the cli	245378 PROVIDER OR SUPPLIER VIEW MANOR HCC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 54 reviewed with floor or wall damage had bathroom sheet rock that was maintained in good repair.	PROVIDER OR SUPPLIER VIEW MANOR HCC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 the context of the context of the 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	PROVIDER OR SUPPLIER VIEW MANOR HCC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 the maintenance director confirmed the damaged wall in the bathroom of room 109. He stated, "tub has the maintenance director confirmed the damaged wall in the bathroom of room 109. He stated, "tub has the maintenance director confirmed the damaged wall in the bathroom of room 109. He stated, "tub has the maintenance director confirmed a qualt of size hole in the wall below the toner 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	PROVIDER OR SUPPLIER VIEW MANOR HCC SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 12/31/5, 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 bound find out a require it was adjace to a "05's mound." It? maintenance director full the wall below the tower apper 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. PA BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152 PREFIX F 465 Constitute and should not be interprived and mission nor an agreement facility of the truth of the facts allege conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was exilely because provisions of state a federal law require it. Without waiv foregoing statement, the facility at with respect to: 1. Resident #6 bathroom wall was repaired by maintenance director conditions and the monthly to estimate the facility of the truth of the facility of th	PROVIDER OR SUPPLIER VIEW MANOR HCC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION) Continued From page 54 reviewed with floor or wall damage had bathroom sheet rock that was maintained in good repair. Findings include: 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, "Ubh has b

Facility ID: 00731

	(X3) DATE SURVEY COMPLETED	
12	2/31/2015	
ZIP CODE		
F CORRECTION STION SHOULD BE THE APPROPRIATE CY)	(X5) COMPLETION DATE	
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;	ZIP CODE F CORRECTION TION SHOULD BE THE APPROPRIATE CY)	

PRINTED: 05/10/2016 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ B. WING 00731 12/31/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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 complian evith all requirements of the information tag number and MN Rule num, er in icated belo v. When a rule contains severa ite -- '-" ire 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 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.

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/29/16

ZNOX11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND LEAN	OI JOHNLOHON	IDENTIFICATION NONDER.	A. BUILDING:		COIVIE	
		00731	B. WING		12/31/	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	sign and date, mak return the original to Health, Division of (Licensing and Certi	e a copy of these orders and of the Minnesota Department of Compliance Monitoring, fication Program; 12 Civic 2105, Mankato, Minnesota		The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule number and corresponding text of the state state out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the survindings are the Suggested Method Correction and the Time Period Former. The Ourth Olumn Which STATES, FROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." the tute/rule ies" ply" nis s which after the s veyors d of or DING OF THIS O DN FOR	
2 265	MN Rule 4658.0089 Resident Health Sta	5 Notification of Chg in atus	2 265			2/8/16
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death.	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an				

6899

Minnesota Department of Health STATE FORM

PRINTED: 05/10/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ B. WING 00731 12/31/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 2 6 5 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 alte treatn ant significant, for example, a need to c soo. Inue in existing i rm of treatment due to a liverse con equences, considering begin a new form of meatment: 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 Based on interview and document review, the Completion Date: 2-8-16 facility failed to notify the physician in a timely

Minnesota Department of Health STATE FORM

Findings include:

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.

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
	PROVIDER OR SUPPLIER	200 EAST	DRESS, CITY, S NINTH AVE TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	R46's discharge ord dated 9/17/15, iden improving with orde occupational therape R46's physician's prindicated diagnoses lumbar region, sepson The physician's prohistory of diverticuling R46's admission Mi 9/24/15 identified a Status score of 13/2 area assessments of R46's care plan, day cognitive impairment return to the common R46's September 2 revealed R46 had received and administered on 9/26/1 licensed practical in the medication administered on 9/26 the medication had since supper. No for effectiveness was centry dated 9/26/15 had received anothes listed as had another suppers and since suppers and since suppers was centry dated anothes listed as had another suppers and suppers and suppers suppers and suppers suppers was centry dated 9/26/15 had received anothes listed as had another suppers and suppers suppers and suppers suppers suppers was centry dated 9/26/15 had received anothes listed as had another suppers s	ders to the nursing home tified a discharge condition of the for physical and by. Trogress notes, dated 9/18/15 to of spinal stenosis of the sis, and urinary tract infection. In gress note also identified a tis of the colon. Trogress note also identified a tis of the colon. Trogress note also identified a tis of the colon. Trogress note also identified a tis of the colon. Trogress note also identified a tis of the colon. Trogress note also identified a tis of the colon. Trogress notes, dated 9/18/15 to sign of the colon. Trogress notes, dated 9/18/15 to sign of the colon. Trogress notes, dated 9/18/15 to sign of the colon. Trogress notes, dated 9/18/15 to sign of the colon. Trogress notes, dated 9/18/15 to sign of the colon. Trogress notes, dated 9/18/15 to sign of the colon. Trogress notes, dated 9/18/15 to sign of the colon. Trogress notes, dated 9/18/15 to sign of the colon. Trogress notes, dated 9/18/15 to sign of the colon. Trogress notes, dated 9/18/15 to sign of the colon. Trogress notes, dated 9/18/15 to sign of the colon. Trogress notes, dated 9/18/15 to sign of the colon. Trogress notes, dated 9/18/15 to sign of the colon. Trogress notes, dated 9/18/15 to sign of the colon. Trogress notes and 9/18/15 to sign of the colon. Trogress notes and 9/18/15 to sign of the colon. Trogress notes and 9/18/15 to sign of the colon. Trogress notes and 9/18/15 to sign of the colon. Trogress notes and 9/18/15 to sign of the colon. Trogress notes and 9/18/15 to sign of the colon. Trogress notes and 9/18/15 to sign of the colon. Trogress notes and 9/18/15 to sign of the colon. Trogress notes and 9/18/15 to sign of the colon. Trogress notes and 9/18/15 to sign of the colon. Trogress notes and urinary tract infection. Trogres	2 265	DEFICIENCY)		
	A nursing progress	note written by LPN-F on				

Minnesota Department of Health
STATE FORM

ZNOX11

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 265	9/25/15 at 8:30 a.m and complaints of rindicated R46 had along with Thorazin after his morning made experienced a the bed and himself anything for breakfard orange juice that had a nursing progress on 9/25/15, at 1:39 large emesis, and the was not feeling well hiccups had subsidicted again. Doctoreceived Maalox and medication used for another small emest documented as had and was described R46's temperature been elevated at 950 A nursing progress p.m. per LPN-F indicted most of the evening hiccups were better but that R46 had be feel right and that we to gag. R46 had easips of water. Additindicated a fax (fact medical doctor (MD condition including temperature at 99.5 feeling chilly.	a., indicated R46 had hiccups not feeling well. The notes oeen given Maalox 30 cc's he and had begun retching redications. In addition, R46 large projectile emesis all over f, and had refused to eat ast, stating he had consumed	2 265	SED		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00704	B. WING		40/0	1 /001 5
		00731			12/3	1/2015
	PROVIDER OR SUPPLIER		DRESS, CITY, 8 NINTH AVE	STATE, ZIP CODE NUE		
VALLEY	VIEW MANOR HCC		ΓΟΝ, MN 56	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	feeling well, and had emesis twice on the appear to have a febeen given to help vitamins had been leading to have a febeen given to help vitamins had been leading to have a febeen given to help vitamins had been leading to have at 1:56 a.m. indicated distended, his bower and he had been had	d been having brown colored afternoon shift which did not be she as noted to emesis. Indeed By LPN-A, dated 9/26/15, and By LPN-A, dated 9/26/15, and showed difficult to hear aving emesis which looked like as noted to be slightly elevated anote written by LPN-A on the number of From a 10 cc's for med/ly ase BM (bowed colors) and sharing with a she are the side him, and	2 265	BED)		
		ng progress note dated n. indicated R46 had been				

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 20.23			
		00731	B. WING		12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		'NINTH AVE ΓΟΝ, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 6	2 265			
		te care hospital with a obstruction, and would need				
	p.m. from the facilit identified that R46 is experienced several throughout the day drink. R46 complainad not been signedays later, when the responded with a statelephone order to the Please do NOT fax need attn [attention]	and had been unable to eat or ned of feeling weak. The fax d off until on 9/28/15, three enurse practitioner (NP)-A tatement including, "Noting transfer to ER on 9/26/15. If regal to tatalons nat at at day T is will be sint to 9/20/15. Plesse review to 9		SED		
	a.m. was reviewed. had appeared distrebeen uncomfortable with dried brown matched the properties of th	ote dated 9/26/15, at 10:36 The ER note indicated R46 essed when examined, had e, and had dry oral mucous aterial on the tongue and lips. In indicated R46's abdomentally distended, mildly tender bowel sounds. In addition, of brown liquid had been stomach after the insertion of R46 had received 2000 ml of renous for hydration. The ER dicated R46 had appeared and verified the admitting bowel obstruction and severe				
	9/26/15, at 11:17 a. he'd been vomiting	nurse's assessment dated m. indicated: R46 had stated for the last two days and his own like stool. R46 had				

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STATE FORM

COMPLETED

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: _____

> B. WING _____ 00731 12/31/2015

NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
VALLEY	VIEW MANOR HCC		NINTH AVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMATION OF LSC IDENTIFYING INFORMATION OF LSC IDENTIFYING INFORMATION OF LSC IDENTIFY INC.	ULL	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 en the ER and the vomit was described as obrown liquid running out of his mouth. R abdomen was very firm, with no bowel so and the abdomen was distended. R46 complained of abdominal pain but was u rate the pain. R46 had his stomach drain nasogastric tube for ten minutes with 140 fluid output after which R46 stated he fel better. R46 was alert and "states we show what ever we have to do. Is comfortable	dark 46's bounds nable to ned via a 00 mL of t much bould do			
	The hospital discharge summary dated to indicated R46 had undergone abdominal to correct the small to correct the small to cardinate developed subsequent to cardinate and reliable post-optileus (disruption in normal to well notility) surgery. The ileus resolved with une reprofit a nasogastric tube; however, comfort were initiated and R46 passed away on the resolved with une reprofit to the resolved with the res	surgery nc had pera ve afte the acement cares		SED	
	During interview on 12/29/15, at 3:07 p.n director of nursing (DON) verified she we expected staff to contact the on-call doct immediately with the urgent clinical issue especially when the resident was vomiting BM-type material and not feeling better.	ould have or es,			
	During interview on 12/29/15, at 3:32 p.m nursing home's health information coordinator/nursing scheduler (HIM) stat LPN-B was not well and was currently in hospital intensive care unit, unavailable finterview. The HIM verified LPN-F had be pool nursing staff.	ed a or			
Minnes	During interview on 12/29/15, at 3:45 p.n acting administrator, who had been the I the time of the incident stated she'd thou	OON at			

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00=04			10/0	
		00731	b. Wind		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
LAMBER			ON, MN 56	152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 8	2 265			
2 265	R46's family had inchospital with a bowelater been found to administrator was uregarding R46's epistated she would had contact/call the onedirectly with concernadministrator stated staff to check the vistatus, appetite and a physical assessmishe thought LPN-A her judgment. She every Thursday night When LPN-A was in on 12/29/15 at 4:02 received report from on 9/25/15, regarding been unaware a fax stated she'd worked prior and was award complaints of not fees the was aware R46 been eating well, are administered Maalox first time she admin LPN-A verified R46 like stool but there was abdomen had also LPN-A was unaward complained of pains subsequently vomit later in her shift (are she'd become conditional sound in the she'd proceeds and she'd proceeds was a ward of pains subsequently vomit later in her shift (are she'd become conditional she'd proceeds was a ward of proceeds and she'd proceeds was a ward of pains subsequently vomit later in her shift (are she'd become conditional she'd proceeds was a ward of pains subsequently vomit later in her shift (are she'd become conditional she'd proceeds was a ward of pains subsequently vomit later in her shift (are she'd become conditional she'd proceeds was a ward of pains subsequently vomit later in her shift (are she'd become conditional she'd proceeds was a ward of pains subsequently vomit later in her shift (are she'd become conditional she'd proceeds was a ward of pains was a war	dicated he was admitted to the el obstruction, but that it had be a narrowed bowel. The mable to recall specifics sode of illness; however, ave expected staff to call and/or primary physician as that were urgent. The dishe would have expected the tal signs, bowel movement of fever status while conducting tent. The administrator stated was a good nurse and trusted further verified LPN-A worked further verified LPN-A worked in the evening nurse (LPN-r) and R46's emesis, but had a had been sent. LPN-A diwith R46 at least one time to the R46's vomiting and the selling well was new for R46. So had thrown up and had not and had subsequently box during the night. LPN-A had helped somewhat the histered it (around 2:00 a.m.). The had emesis of what looked was no odor. She verified his seemed a little distended.	2 265			

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC	200 EAST	DRESS, CITY, S NINTH AVE TON, MN 56	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 265	not call the RN on cher concern. LPN-along the paperwor nurse, LPN-B, who on 9/26/25. LPN-A an assessment to for During the interview there had been a his she had noted when pass along to the distance of the pass along to the distance of the physicial symptoms, and that there had been a dephysician notification. During interview on medical director was would have expected they filled out the past the hospital. The malthough R46 may hanyway, prompt men him comfortable. The effect of delayed more related to R46's mental to R46's mental the state of the would have called the clinic and R46 began vomiting stated faxing medicing p.m. was inappropring the along the concerned the concer	call nor notify the physician of A indicated she had passed k and her concern to the day arrived on duty at 6:00 a.m. stated she'd told LPN-B to do ollow up on R46's condition. at LPN-A stated she thought story of small bowel concerns in filling out the paperwork to ay shift personnel. Interview on 12/30/15, at 9:12 tor stated LPN-A should have an sooner about R46's the remaining care and	2 265	SED		

Minnesota Department of Health STATE FORM

PRINTED: 05/10/2016 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00731 12/31/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 2 6 5 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 vou 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 ap arent 'isco mortula was sudden in onset, a marked channe (i.e. mo ? severe) in relation to isuc signs and symptoms and was unrelieved to mea tire already prescribed. The policy further increased 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.

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

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Minneso	<u>ta Department of He</u>	aith			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00731	B. WING		12/31/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
VALLEY VIEW MANOR HCC 200 EAST			NINTH AVE	NUE	
VALLET	VIEW MANOR HCC	LAMBER	FON, MN 56	152	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
2 265	Continued From pa	ge 11	2 265		
	(21) days.				
2 302	MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	2 302		2/8/16
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144				
	Alzheimer's disease or related of	ity serves persons with disorders, whether in a eral unit, the facility's direct			
	care staff and their superviso care.	rs must in the ned in de nentia		SED	
	(b) Areas of require (1) an explanation of related disorders;	ed rainin, inc Ide. of Alzheimer's disease and			
	(2) assistance with	activities of daily living; with challenging behaviors; skills			
	(c) The facility shall written or electronic training program, th	provide to consumers in c form a description of the ne categories of employees ncy of training, and the basic			
		document compliance with			
	by:	ent is not met as evidenced		Completion Date: 2.2.40	
	facility failed to prov	and document review, the vide to residents and/or embers information regarding:		Completion Date: 2-8-16	

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		00731	B. WING		12/3 ⁻	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 12	2 302			
	training, how often, training provided. T	staff received, who received and a description of the his had the potential to affect of the facility and their				
	Findings include:					
	consists of all requi	eimer's training program red elements, staff are trained tively impaired on new hire Il module each quarter related eimer's care.				
	provided to resident admission to the fa	n ssion orm and documents and heir families upor its indicate of there was a cong Alzheimer's training.				
	director of nursing (information with the they are not providing	on 12/30/15, at 3:15 p.m. the DON) stated she reviewed the administrator and verified ng written information to to Alzheimer's training start "working on it".				
	DON or designee or procedures in additi information is being their families regard training. Provision of	HOD OF CORRECTION: The ould review their policies and ion to insuring updated provided to residents and/or ling Alzheimer's/Dementia of training/notification could the quarterly QA&A meeting.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00731	B. WING		12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 13	2 565			
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use		2 565			2/8/16
		omprehensive plan of care personnel involved in the				
	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 activities for activities. Findings include: When interviewed on 12/29/15, at approximately 8:50 a.m. the director of nursing (DON) confirmed			Completion Date: 2-8-16		
	further indicated sta resident through ge	r understand English. DON aff communicated with the estures and facial expressions. the facility on 9/5/14, with				
	diagnoses including disturbance, cogniti chronic obstructive	y dementia without behavioral ve communication deficit, pulmonary disease (COPD), and difficulty walking per the				
	indicated the reside but occasionally ne- structuring leisure a wellness. Intervent plan:	activities dated 10/12/15, ent was primarily independent eded some guidance with activities that promote ions identified on the care om; please play music per				

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NAME OF PROVIDER OR SUPPLIER VALLEY VIEW MANOR HCC SUMMARY STATEMENT OF DEFICIENCIES (A4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 2565 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 wa ambute with the assistance of two states, and distinct of the half staff seated him back in the w/c, removed the transfer belt and transferred him to	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
VALLEY VIEW MANOR HCC 200 EAST NINTH AVENUE LAMBERTON, MN 56152 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGK (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 wa ambutter with the assistance of two states, and states pusined the length of the hall staff seated him back in the w/c,			00731	B. WING		12/3	31/2015
PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG			200 EAST	NINTH AVE	NUE		
(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 wa ambu ite with the assistance of two sta, a d sta pusined the residents wheelchair w/c) whin him down we west cityside hallway. After Fo ambunated the length of the hall staff seated him back in the w/c,	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETE
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	() () () () () () () () () ()	(2.) Recreation/We exercise, listening to wrestling and war mesensory and 1:1 time (3.) EMOTIONAL: (individual music enject) (4.) PHYSICAL: Enwell-Fit program to individual cardio. The would work on puzz period. On 12/29/15, R6 was 1:16 p.m. R6 was esistance of two siresidents wheelchait west cityside hallwallength of the hall staremoved the transfethe dayroom area to Staff moved him in R6 propelled himsed dayroom. -At 1:27 a.m. nursing a round shaped sermultiple-colored hold bungy type cord. The stretched and manifitem, talking out loutheld the item, he did he attempt to manipal NA-A left the area and R6. -At 1:34 p.m. a staff the middle of the dayroom.	ellness preferences include: o music, watching TV (enjoys novies) food related activities, i.e. Offer ipod or CD player for ioyment. Incourage participation in Include group exercise and/or ne activity goal indicated R6 eles in day room by the review as observed continuously from p.m. a ambuter with the tat, and state pushed the aff seated him back in the w/c, er belt and transferred him to ocated by the nurses' station. If ont to the television and then elf in the w/c throughout the ag assistant (NA)-A brought R6 insory item which consisted of ellow tubes held together with a his enabled the object to be pulated. R6 accepted the d constantly. Although R6 d not appear interested nor did oulate or pull the sensory item. Effective transported R6 from ayroom to a table with another	2 565	SED		

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		' NINTH AVE ΓΟΝ, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	sensory object remainteraction between remained at the tab began to propel the -At 2:00 p.m., R6 w top of covers with s given to him earlier was not touching not though he appeared time, a popcorn an in the activity room. -At 2:07 p.m. it was on edge of bed with sensory item remain again noted that R6 interested in this series water, greeted -At 2:14 p.m. staff of fresh water, greeted fresh water, greeted -At 2:30 p.m., R6 w bed in room with the a shoe on his lap, resensory object was music was playing in -At 2:39 p.m., R6 resthe bed attempting shoe. R6 had a newere present in the Coffee social and wheld in the dining room of the restriction of the new continued to sit on eremove the laces from the continued to sit on eremove the laces from the continued to sit on eremove the laces from the continued to sit on eremove the laces from the continued to sit on eremove the laces from the continued to sit on t	ained on his lap. No staff and R6 occurred. R6 ble a short time and then w/c around the dayroom. as observed lying in bed on hoes on. The sensory item was placed on his legs. R6 or handling the item even d to be wide awake. At this d movie activity was occurring noted that R6 was sitting up and on resident's lap. It was a seated on the edge of his eleft shoe off and was holding emoving the laces. The no longer visualized. No note the laces from his left bulizer mask on and no staff room during this observation. For ord games activities were	2 565	SED		

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	entered the room a medication aide (TM and asked whether shoe". NA-C aske supposed to have to that if NA-C could good transfer him in about it. On 12/29/seated on the side without laces. R6 as shoe. The Wellness schedule for 4:00 poseated on edge of the and was attempting the shoe. This active 2:30 p.m. (almost 22.30 p.m. (almost 22.30 p.m.) (a	It shoe. At 3:10 p.m. NA-C and greeted R6. Trained MA)-A also entered the room R6 was still "working on his d TMA-A whether R6 was the shoe. TMA-A responded get it laced and on R6, they are the scalar and not worry 15, at 3:57 p.m. R6 remained of bed, holding his left shoe appeared to be examining the se group was on the activity m. At 4:17 p.m. R6 remained bed, holding onto the left shoe at the property of the second specific states.	2 565	BED		

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Minnesota Department of Health

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.					SURVEY LETED	
		00731	B. WING		12/3	1/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC	200 EAST	DRESS, CITY, S NINTH AVE TON, MN 56	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	noted between staff offered/assisted to throughout the note interact with the resident of the property of the provided in the resident of the provided in the resident of the provided in the resident of the provided in the main and served a snack whith the main dining room where held in the main are served a snack whith e main dining room with 2 openings. Resident of the provided in the main and	f and R6. R6 was not the church activity at anytime od observations nor did staff	2 565	SED		

Minnesota Department of Health

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 12/0	1/2010
VALLEY	VIEW MANOR HCC		NINTH AVE	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	(wrestling and war is care plan, she indice preferences. When were reviewed to sure resident had attend highlighted and/or of had been involved is observations. When further interval. The AD provide activity sheets whice activities on 8 of the activity sheet dated resident was offered stated she sat next he did really well. It provide documenta November 2015 and sheets for October plan of care was not sheets for October plan of care was not concluding: demential disorder, and chroned disease (COPD) per The report further is thospice services or degeneration of the R23's care plan lass resident was dependent and providing activities if [resident of room events. (2) participation in small interactions (3) EM	movies) documented on R6's rated being unaware of these in the current activity sheets obstantiate the activities each red, there was nothing documented indicating that R6 in activities during the days of diewed on 12/31/15, at 10:21 red 10 days of December 2015 in indicated R6 was offered at 10 days. AD stated the 12/21/15, indicated the die of a 'vit soffered in diprovided 5 days of activity 2015. It was confirmed the of implemented as written. In 1/6/15 with diagnoses are paranoid personality, mood dic obstructive pulmonary for the facility diagnosis report. Dentified R23 was admitted to a 5/15/15 due to senile a brain. It revised 11/9/15, indicated the indent on staff for structuring ties that promote wellness cognitive deficits. Interventions 1 bedside/in-room visits and the name] is unable to attend out 1 COGNITIVE: Encourage	2 565	SED		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		.,
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	ENVIRONMENTAL body language relative [Resident name] Repreferences included word search, TV and R23 was observed from 1:14 p.m. until A popcorn and moven, in the activity restrictivity held at 2:30 did not offer R23 the activity. R23 was again obsectivity. R24 was again obsectivity. R25 was again obsectivity. R26 was again obsectivity. R27 was again obsectivity. R27 was again obsectivity. R28 was again obsectivity held at 2:30 did not offer R23 the activity. R29 was again obsectivity held at 2:30 did not offer R23 the activity. R29 was again obsectivity held at 2:30 did not offer R23 the ac	cobserve [resident name] ted to overstimulation ecreation/Wellness individual eligible, walks, magazines, ad listening and playing music." continuously on 12/29/15, 3:56 p.m. while lying in bed. to activity was held at 1:30 from and the coffee social p.m. in the dining room. Staff to opportunity to attend either at able while a church se vice held in the activity room. The mained in the geri-chair with an approached another with located near the cityside asked whether she wanted to 3 opened her eyes when the teleft for church but looked er eyes when they left the oppoached R23 at 10:23 a.m. wanted to lay down; R23 A did not give her the d the church activity before the room. Was observed lying in bed with a Wellness activity was in not been given the opportunity	2 565	SED		

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP			SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 .2/0	.,,
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	the cityside dayroor member piano play to offer attendance When interviewed of NA-B and NA-A corwith her morning cate activities, she often down. Both NA's of R23 attendance at R23 had been tearforceiving care and rather lie down. When interviewed of AD stated R23's activities activities activities and in the constant of the const	m with a resident's family ing. Staff were not observed to the activity to R23. on 12/30/15, at 11:55 a.m. of firmed they had assisted R23 ares, stating that when offered refuses as prefers to lie confirmed they had not offered the morning church activity as all that morning when they felt the resident would or 12/00/15,	2 565	SED.		

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Minnesota Department of Health
STATE FORM

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/3	31/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 565	Continued From pa	ge 21	2 565				
	develop, review, an procedures to ensure plans according to the needs. The director could educate all agand procedures. The designee could devensure ongoing contaudits could then be QA&A meetings.	d/or revise policies and re the facility develops care the residents individualized of nursing (DON) or designee oppropriate staff on the policies are director of nursing (DON) or delop monitoring systems to impliance. The results of these is presented at the quarterly		SED			
2 830	Proper Nursing Car Subpart 1. Care in receive nursing care custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ang home resident must be out possible unless there is a the attending physician that the in in bed or the resident	2 830			2/8/16	
	This MN Requirements	ent is not met as evidenced					

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Minnesota Department of Health STATE FORM

ZNOX11 If continuation sheet 22 of 61

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		19/2	1/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 12/3	1/2013
	VIEW MANOR HCC	200 EAST	NINTH AVE	NUE		
			ON, MN 56	T		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 22	2 830			
	facility failed to provand services for 2 creviewed who had be resulted in actual haprolonged discomforelated to delayed retransfer to an inpatiobstruction. In add provide appropriate dementia care for 1 who had dementia speak/understand E			Completion Date: 2-8-16		
			15	SED		
	indicated diagnoses lumbar region, seps	rogress notes, dated 9/18/15 s of spinal stenosis of the sis, and urinary tract infection. gress note also identified a tis of the colon.				
	9/24/15 identified a Status score of 13/	inimum Data Set (MDS), dated Brief Interview for Mental 15 (cognitively intact). No care were completed with the MDS.				
		ted 9/30/15 identified no nts and that R46 desired to unity.				
	revealed R46 had r 30 cubic centimeter	015 medication sheets eceived Maalox (an antacid) 's (cc)'s on 9/25/15 a total of ate, as well as one dose at				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0731

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

200 EAST NINTH AVENUE

		00731				12/31/2013	
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	T ADDRESS, CITY, STATE, ZIP CODE			
VALLEY	VIEW MANOR HCC			NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FI SC IDENTIFYING INFORMATI	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
2 830	Continued From pa	ge 23		2 830			
	licensed practical number the medication administered on 9/2 the medication had since supper. No for effectiveness was contry dated 9/26/15 had received another stomach and emessifisted as had another the other doses administration of the other doses.	n ເວພາ. 'en , ຣາ ເຮ	pack of a dose icated ch upset or ent I R46 an upset was one of up				
	9/25/15 at 8:30 a.m and complaints of n indicated R46 had be along with Thorazin after his morning m had experienced a the bed and himself	., ndicat JF 16 had had not record we in the not so an given N alox 30 e and had begun record edications. In addition large projectile emesisf, and had refused to east, stating he had con	ic ups ote: cc's ning , R46 s all over		SED		
	on 9/25/15, at 1:39 large emesis, and the was not feeling well hiccups had subsidestarted again. Doctoreceived Maalox and medication used for another small emest documented as have and was described R46's temperature been elevated at 95 large emesis.	note documented by L p.m. indicated R46 ha hat the resident had st . The notes indicated ed for a while but had umentation indicated F id Thorazine (an antips r antiemetic properties is afterward. The emering had food particles as having a colicky of was documented as h 0.0 degrees Fahrenhei	d a tated he his then R46 had sychotic b) with esis was present dor. aving t (F).				
	A nursing progress	note dated 9/25/15, at	0.00				

Minnesota Department of Health

STATE FORM 5899 ZNOX11 If continuation sheet 24 of 61

	ta Department of He		(VO) MULTIPL	E CONCERNICATION	(VO) DATE	OLIDVEY.
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00731	B. WING		12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
\/A \(\bar{\alpha}\)	VIEW MANOR HOO	200 EAST	NINTH AVE	NUE		
VALLEY	VIEW MANOR HCC	LAMBERT	ON, MN 56	152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	p.m. per LPN-F indimost of the evening hiccups were better but that R46 had be feel right and that w to gag. R46 had easips of water. Additi indicated a fax (facs medical doctor (MD condition including temperature at 99.5 feeling chilly. A nursing progress p.m. per LPN-F indifeeling well, and had emesis twice on the appear to have a fe been given to help witamins had been had b	icated R46 had stayed in bed g. The note indicated R46's rover the early evening hours een stated his tummy still didn't whenever he moved he began aten Jell-O for supper and had ionally, the documentation simile) had been sent to a)-A with an update on R46's that R46 had an elevated is degrees F and complained of anote dated 9/25/15, at 11:05 in the control of th	2 830	BED		
	9/26/15, at 9:57 a.m	note entered by LPN-B, dated in indicated R46 had two reenish liquid thick with pieces				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	'		2 830			
	an acute care hosp order was received emergency room (E indicated R46's data agreed to meet him facility at 8:45 a.m. A faxed physician's present in R46's rec	In addition, the note indicated ital had been called and an to transfer R46 to their ER) via ambulance. The note ughter was updated and had at the hospital. R46 left the order dated 9/26/15 was cord and verified the physician r ambulance to the acute care				
	9/26/15, at 2:06 p.n admitted to the acu	ng progress note dated n. manda of Frontial bean te care hispital with a ()succition, ma would read	15	SED		
	p.m. from the facilit identified that R46 I experienced severa throughout the day drink. R46 complain had not been signed days later, when the responded with a sitelephone order to the Please do NOT fax need attn [attention [physician] - today staring for response	order sent on 9/25/15, at 6:05 y to R46's primary physician had emesis since 8:30 a.m., all rounds of hiccups and had been unable to eat or ined of feeling weak. The fax d off until on 9/28/15, three enurse practitioner (NP)-A tatement including, "Noting transfer to ER on 9/26/15. in regard to situations that 1 that day. This will be sent to 8/28/15. Please review the procedure. Thx [Thanks]."				
	a.m. was reviewed. had appeared distre- been uncomfortable with dried brown ma	The ER note indicated R46 essed when examined, had e, and had dry oral mucous aterial on the tongue and lips. r indicated R46's abdomen				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		B. WING		10/01/0015	
	00731	B. WING		12/3	1/2015
NAME OF PROVIDER OR SUPPLI			STATE, ZIP CODE		
VALLEY VIEW MANOR HC	}	· NINTH AVE FON, MN 56			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
with no apprecia 1800 milliliters (I drained from R4 a nasogastric tul normal saline ini physician's note quite dehydrated diagnoses of sm dehydration. The ER registers 9/26/15, at 11:17 he'd been vomitied three tir the ER and they brown liquid run abdomen was wand the abdomen complained of a rate the pain. Repaired the pain. Repaired the pain asogastric tuber fluid output after better. R46 was what ever we had to correct the sm developed substanticoagulation is ileus (disruption surgery. The ileus of a nasogastric were initiated and During interview director of nursir	page 26 usely distended, mildly tender ole bowel sounds. In addition, all) of brown liquid had been as stomach after the insertion of its stomach after the insertion of its endicated R46 had appeared and verified the admitting all bowel obstruction and severe districted and indicated: R46 had stated as its indicated: R46 had his bro in its indicated: R46 had his stomach drained via a for ten minutes with 1400 mL of which R46 stated he felt much alert and "states we should do be to do. Is comfortable now." That ge summary dated 10/5/15, discombinated undergone abdominal surgery all bowel obstruction, and had aguent cardiac and assues as well as post-operative in normal bowel motility) after the its resolved with the replacement and the passed away on 10/5/15. On 12/29/15, at 3:07 p.m. the gip (DON) verified she would have contact the on-call doctor.	2 830	SED		

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-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILDING.			
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		' NINTH AVE FON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	immediately with the specially when the BM-type material and During interview on nursing home's head coordinator/nursing LPN-B was not well hospital intensive of interview. The HIM pool nursing staff. During interview on acting administrator the time of the incidence of the in	e urgent clinical issues, e resident was vomiting and not feeling better. 12/29/15, at 3:32 p.m. the alth information scheduler (HIM) stated I and was currently in a are unit, unavailable for verified LPN-F had been a 12/29/15, at 3:45 p.m. the r, who had been the DON at the r, who had been the post riction put mat it rad to a narrow I bowel. The recall specifics isode of illness; however, ave expected staff to call and/or primary physician ans that were urgent. The dishe would have expected the ital signs, bowel movement of fever status while conducting the recall signs, bowel movement of the recall signs	2 830	BED		

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Minnesc	<u>ita Department of He</u>	eaith				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00731	B. WING		12/31/2015	
		00731			1 12/3	1/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HOO	200 EAST	NINTH AVE	NUE		
VALLET	VIEW MANOR HCC	LAMBERT	TON, MN 56	152		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON O	(X5)
PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
2 830	Continued From pa	ge 28	2 830			
	heen eating well ar	nd had subsequently				
		ox during the night. LPN-A				
		had helped somewhat the				
		nistered it (around 2:00 a.m.).				
		had emesis of what looked				
		was no odor. She verified his				
	abdomen had also	seemed a little distended.				
	LPN-A was unawar					
	complained of pain.					
		ed and it looked more like BM				
		ound 5:00 a.m.) at which time				
		erned that he may have				
		rith his small bowel. LPN-A				
		ed to fill out all the transfer				
		sk large har c, nowever, did				
		A ruic red s = riau pass d				
		k and he co pern to the car				
		arrived on duty at 0.00 a.m.				
		stated she'd told LPN-B to do				
		ollow up on R46's condition.				
		v, LPN-A stated she thought				
	there had been a hi	story of small bowel concerns				
	she had noted whe	n filling out the paperwork to				
	pass along to the d	ay shift personnel.				
		nterview on 12/30/15, at 9:12				
		tor stated LPN-A should have				
		an sooner about R46's				
		t she had not been aware				
	physician notification	elay in his nursing care and				
	priyaician notincatio	or or this condition.				
	During interview on	12/30/15, at 2:11 p.m. the				
		is interviewed and stated she				
		ed nursing staff to call when				
		aperwork to transfer R46 to				
		nedical director stated				
		have subsequently expired				
		edical care would have made				

Minneso	<u>ta Department of He</u>	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 29	2 830			
	effect of delayed merelated to R46's merelated he would have called the clinic and R46 began vomiting stated faxing medic p.m. was inappropred to attended at that he'd been concerned ischemic bowel who due to the delay in after his symptoms made some "depred hospital transfer on were a "sidebar" and issue. MD-A confirmmore comfortable if sooner in the ER.	the medical director stated the edical care/interventions edical outcome was difficult to so not his usual physician. 12/31/15, at 9:27 a.m. 13/31/15, at 9:27 a.m. 14/31/15, at 9:27 a.m. 15/31/15, at 9:27 a.m. 16/31/15, at 9:27 a.m. 16/31/15, at 9:27 a.m. 17/31/15, at 9:27 a.m. 18/31/15, at 9:27 a.m. 18/31/1		SED		
	SBAR last revised of notification of the playmptom, sign or a sudden in onset, a severe) in relation that and was unrelieved prescribed. The posection related to a immediate notification required when there	entitled Change in Condition 3/15, indicated immediate hysician was required for any pparent discomfort that was marked change (i.e. more o usual signs and symptoms by measures already slicy further indicated in a bdominal distension that on of the physician was a was rapid onset, or presence ess, fever, vomiting or Gleeding.				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00731	B. WING		12/3	31/2015
	PROVIDER OR SUPPLIER	200 EAST	DRESS, CITY, S NINTH AVE FON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Review of R21's M Record (MAR) date that blood sugar (B- five (5) times per da - 12/29/15 there we which were docume deciliter (dL) and at documented BS lev mg/dL. Although th fluctuated dramatic physician notificatio registered greater t A physician's order, Insulin Regular Hur (ml) Inject as per sl ordered dosage "gr units". A physician's order, Insulin Glargine Sol subcutaneous (SQ) sliding scale with R unit/ml. BS reading diabetic educator w listed for notification hypo (low) or hyper During interview on licensed practical n were no protocols, notify the medical d LPN-C stated she w how the resident fe BS-which she ident 500's". On 12/30/15, at 2:3 would notify the ME	edication Administration and December 2015, identified S) readings were monitored ay. Between the dates of 12/1 are 44 blood sugar (BS) levels ented as 400 milligrams (mg)/200e, with 25 of those are readings higher than 430 are resident's blood sugars ally, there had not been an of blood sugars which	2 830	SED		

PRINTED: 05/10/2016

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
AND PLAN OF CORRECTION

O0731

STREET ADDRESS, CITY, STATE, ZIP CODE

VALLEY VIEW MANOR HCC

PORM APPROVED

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:
B. WING
B. WING
200 EAST NINTH AVENUE
LAMBERTON, MN 56152

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 proto or on "abo would telephone adjustments and this was w' at i sulin char res were based upon. Team of the result of and nursing staff were supposed to can the medical provider on call and/or the triage nurse related to changes in status. The diabetic educator further indicated she thought BS		-		I		
Camberton, MN 56152 Camberton, MN 56152		•			NAME OF PROVIDER OR SUPPLIER	NAME OF
SUMMARY STATEMENT OF DEFICIENCIES PREFIX CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 830 Continued From page 31 2 / 2830 2 / 330 2 / 330 2 / 330 2 / 330 2 / 330 2 / 330 2 / 330 2 / 330 2 / 330 2 / 330 2 / 330 3 / 330		_		CC	VALLEY VIEW MANOR HCC	VALLEY
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 proto or in the sum of the complete stated R21 had a his try of ein a brittle dia. c and nursing staff were supposed to cain the medical provider on call and/or the triage nurse related to changes in status. The diabetic educator further indicated she thought BS	(X5) COMPLETE DATE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ID PREFIX	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	PREFIX (EACH DEFICIENC	PRÉFIX
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diabetic educator indicated she received weekly reports of R21's BS results. She further stated the clinic has a proto or or 'iab and modic tion adjustments and this was what is sulin charnes were based upon. The or oetic addator further stated R21 had a his pryothein a brittle dialence and nursing staff were supposed to dair the medical provider on call and/or the triage nurse related to changes in status. The diabetic educator further indicated she thought BS				MD was not updated. LPN-D R21 frequently has BS readings dL and the facility standing orders units of regular insulin if the BS an 350 mg/dL. LPN-D indicated meter read "high" it was the result 00 mg/dL and she would telephone all at the hospital to report the	mg/dL and the MD further stated R21 above 400 mg/dL a read to give 6 units was greater than 3 when the glucome of a BS over 600 n the nurse on call a reading.	
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.		SED		or indicated she received weekly is BS results. She further stated proto on the liab homeolic tion at this was what is sulin charnes on. The or petic addition a brittle dial of the liab his bry of the eigenstates. The diabetic of were supposed to call the error call and/or the triage nurse ges in status. The diabetic or indicated she thought BS dibbeen identified when R21 was reged from the the hospital on indicated the parameters would ermined by the discharging MD. In on 12/30/15, at 3:12 p.m. RN-B and there were facility parameters are readings. They referenced the on the facility's standing orders would be the practice they individualized orders were indicated if a resident was ne would notify the physician tanding order instructions. RN -B atted they were not aware of the dition policy related to immediate	diabetic educator is reports of R21's BS the clinic has a property of R21's BS the clinic has a property of R21's BS the clinic has a property of R21 had a hand nursing staff was medical provider or related to changes educator further imparameters had be recently discharged 12/5/15. She indicate have been determined buring interview or and RN-C stated the for reporting BS redocumentation on and stated that wo followed unless indicated that wo followed unless indicated the standard RN-C indicate Change in Conditions.	

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00731			12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 12/0	1/2010
			NINTH AVE	•		
VALLEY	VIEW MANOR HCC	LAMBERT	TON, MN 56	152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From page 32		2 830			
	everyone is aware of	of this policy".				
	indicated she had be a months at the faction BS checks which area, wear gloves, a resident had orders specific insulin order "high" reading she was for direction. In the R21 LPN-E indicated ordered SS dose are then recheck in the whether the BS was stated she would provide the state of the	12/31/15, at 8:36 a.m. LPN-E been employed as an LPN for illity and had received training h included: to test in a private and follow MD orders if the sfor a sliding scale (SS), or a er. LPN-E stated if there was a would contact the MD on call instance of a 400+ reading for ed she would administer the nd recheck in one hour and following hour to determine a seponding simple in that a mistury o. BS in the indicated R21 dic not story follow up but this is what				
	the facility's medica resident would have from the hospital fo physician stated R2 before admission to history of blood sug that the resident wawhen her blood sug However, stated if s for an elevated blood provide specific ord required to recheck results. She stated, 'hi' because they had blood sugar is below to initiate the hypogindicated she would	4 a.m. R21's physician, also al director, stated typically a e a specific order that comes r sliding scale insulin. R21's 21 had been her patient even to the nursing home, and had a gars fluctuating "all over" but as usually most comfortable gars ran over 300 mg/dl. She'd received a telephone call but be a sugar level she could lers as to when staff were at the BS and call back the "they call if the meter reads ave nothing to base it off. If the w 70 mg/dL staff would need allycemia protocol." She further dexpect staff to notify the clinic to update on BS readings that				

Minnesc	<u>ita Department of He</u>	alth				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00731	B. WING		12/3	1/2015
		00101			12/5	1/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC	200 EAST	NINTH AVE	NUE		
VALLET	VIEW WANOR FICE	LAMBERT	TON, MN 56	152		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
2 830	Continued From pa	ge 33	2 830			
	were outside range					
	word datalad range	•				
	When interviewed of	on 12/31/15, at 1:00 p.m. the				
		DON) reviewed the December				
	2015 documentatio	n of R21's BS readings and				
	indicated she was u	unaware of the wide fluctuation				
		R21 which were over 430				
		ned she would have expected				
		tending MD and/or the on-call				
		with the Change in Condition				
	when to Report to	the MD/NP/PA policy.				
	The facility's policy	related to physician				
		d sugar fluctuations, entitled,				
		n viigi. 7 R oon to th	7			
		ne (NP)/p ysi ian assist, nt				
		c iue. bloc sugars grate				
	than 430 mg/dL (or	n achink registers high) ii				
		ing sliding scare mount should				
	, ,	orted to the physician or nurse				
	practitioner (NP)."					
	Maria internaliance de	10/00/15				
		on 12/29/15, at approximately confirmed R6 was unable to				
		nderstood, and staff				
		ng gestures and facial				
	expressions.	ig gootaroo ana raolar				
		tic report indicated R6 was				
		lity in 2014, with diagnoses				
		without behavioral disturbance				
	with a cognitive con	nmunication deficit.				
	Dele appuel MDC -	scossmont dated 10/0/15				
		ssessment dated 10/9/15, nt had severely impaired				
		wandering that significantly				
		acy of others, physical				
		thers 1-3 days, other behavior				
		s others 4-6 days but less				
		S also indicated R6 required				

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDING.			
		00731	B. WING		12/3	31/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE FON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 830	extensive assistand locomotion on/off upersonal hygiene. neither the resident was able to comple preference portion of R6's care plan date falls related to (r/t) hyweakness, gait/bala incontinence, hearing impaired cognition, needs. Intervention meet needs, encou exercise, physical a improved mobility, at three times daily, rewall or objects, use The care plan further problem r/t hearing Interventions including resident/family concommunication difficulty were unable to communication difficulty were unable to communicatio	the with bed mobility, transfer, nit, dressing, toilet use, and The MDS further indicated nor family/significant other te the daily and activity of the assessment. In the daily and activity of the assessme	2 830	BED		

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
			ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 35	2 830			
	his w/c.					
	that was rounded in multiple-colored hol- type cord enabling manipulated. R6 ac loud constantly and	brought R6 a sensory item a shape and consisted of allow tubes held together with a the object to be stretched and excepted the item, talking out NA- walked away. R6 held appear interested, nor did he oulate the object.				
	the middle of the da resident. R6 continu sensory object remainteraction with staf remained at the tab	f member transported R6 from ayroom to a table with another used to verbalize while the a source is a observed. R6 in R6 vas observed. R6 is short time and the nealf in v o a bund the	15			
	nurses' station. LPN	arted to propel behind the N-C redirected the resident and then assisted him to his				
	to the drinking founhad a plastic mug a water from the foun approached R6 and mug with water ther mug. R6 accepted to mumble out loud west hallway toward Once R6 made it to intercepted the resignoom.	opelled himself out of his room tain in the west hallway. R6 and was attempting to obtain tain. A staff member disassisted him with filling the replaced the cover on the the water mug then continued and propel himself down the disthe administrative offices. The end of the hallway, staff dent and returned him to his				
		as lying in bed on top of es. A sensory item the				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. DUILDING			
		00731	B. WING		12/3	1/2015
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 36	2 830			
	resident was holding earlier was on the resident's legs. R6 eyes were wide open.					
	bed with feet dangli on his lap. The resignaying attention to t					
		as seated on the edge of his was off his foot, as he held his ed out the laces.				
	bed in room attempleft shoe. Coffee so was being conducte time. At 2:56 p.m. Fix bed having success his shoe. At 3:10 p. and greet him. A trace of the resident was still "wasked if R6 was sull TMA-A responded to and on the resident chair and not worry p.m. R6 seated on sunlaced shoe. A we begin at 4:00 p.m. Gives still on the edgre-lace his shoe. To was still on the side of the shoe. The same still on the edgre-lace his shoe.	entinued to sit on the edge of sting to pull the laces out of his of an and wor games citivity ex in the minital room at hat RE continued a sition edge of silly renewed the laces filly renewed the laces filly renewed asked if the room and asked if the room and asked if the rorking on his shoe." NA-C eposed to have the shoe. That if she could get it laced, then they could put him in his about it. On 12/29/15, at 3:57 side of bed examining the ellness group was scheduled to On 12/29/15, at 4:17 p.m. R6 e of the bed, attempting to his activity had been 30 p.m. or nearly two hours.		SED		
	significant staff to re the three hour conti 12/29/15. The resid object though staff could be used or sp	ched and/or involved in any esident communication during inuous observation on dent was handed a sensory failed to model how object pend time with the resident.				

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
VALLEY	VIEW MANOR HCC		NINTH AVE			
			ON, MN 56		211	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 37	2 830			
	eventually put into be wide awake.	ed him to his bedroom and bed though the resident was				
	following times: - At 7:50 a.m. R6 w the corner of the dir independently. The	as seated alone at a table in ning room eating breakfast table was pushed flush to the R6's back was to the other ed the wall.				
	to the Cityside dayr table. Staff handed shaped sensory oby when manipulated. without further interbehind him on the sto propel himself pathe dining room to t LPN-C was standin understood, he voc R6 he had already resident back to his resident's room at 8 bare mattress and pathenals.	as assisted in the w/c by staff oom and was situated at a life and tick of our official that so hade sould that the that so hade sould at the nurses' station towards he medication cart where g. Although R6 could not be alized loudly. LPN-C informed eaten and assisted the scroom. LPN-C left the 8:05 a.m. R6 was lying on the billow without a pillowcase. ited at the end of the bed. R6 e grab bar, attempting to sit				
	bed and the w/c wa the brakes locked. located on the seat was wearing shoes the side of the room surveyor alerted the walking by to quest	as seated at the edge of the s positioned next to bed with R6's tennis shoes were of the w/c. At 8:36 a.m. R6, and was ambulating along as he felt the wall. The e administrator who was ion whether R6 was capable bulation. The administrator				

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	redirected R6 to his administrator asked oxygen (O2) as he O2 was applied via administrator left the At 8:49 a.m. R6 repropelled himself frentered another rest the hall. Upon entered another rest the hall. Upon entered redirected R6 back -At 10:04 a.m. a characteristic the activity room. R himself down the wast the corner, the administrator was redirection of the east hallway. R6 then entered in the east hallway to dayroom. No verbal interaction was noted and was identified oplanned intervention seated in w/c in City station when the activity and walk remained seated at the control of the east hallway to dayroom, said "Hi" on the TV and walk remained seated at the control of the east hallway to dayroom, said "Hi" on the TV and walk remained seated at the control of the east hallway to dayroom, said "Hi" on the TV and walk remained seated at the control of the east hallway to dayroom, said "Hi" on the TV and walk remained seated at the control of the east hallway to dayroom, said "Hi" on the TV and walk remained seated at the control of the east hallway to dayroom, said "Hi" on the TV and walk remained seated at the control of the east hallway to dayroom, said "Hi" on the TV and walk remained seated at the control of the east hallway to dayroom, said "Hi" on the TV and walk remained seated at the control of the east hallway to dayroom, said "Hi" on the TV and walk remained seated at the control of the east hallway to dayroom, said "Hi" on the TV and walk remained seated at the control of the east hallway to dayroom the east hallway to dayroom.	times ambulate, and wheelchair. The Ref whether he needed his was heavily breathing. The a nasal cannula and the e room. The room via the w/c and sident's room located across wing the doorway, kg)-A intervened and	2 830	BED		

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-	NT OF DEFICIENCIES OF CORRECTION			(X3) DATE COMP	E SURVEY IPLETED	
		00731	B. WING		12/3	1/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC	200 EAST	ORESS, CITY, S NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	-At 2:16 p.m. NA-B R6 to ambulate, hor stand when prompt seconds. The trans staff left the resident staff left the resident rate of the dining rowhile located in the room, partitioned of R6 was offered his routinely had been strom the other resides snacks in the main when R6 finished his around the front are designated table. Nhe was assisted out the direction of his rinterviewed on 12/3 cited a communicate with the attempted any alter unfair to R6. TMA-A approximately month when interviewed of licensed social work they were unsure we able to talk to his fa Although they had recontact his family attempting.	and NA-A attempted to assist wever, the resident did not ed for approximately 30 after belt was removed and the out. as in the dining room where tivity was held in the main from. R6 was served a snack front area of the main dining if by a wall with two openings. snack at the table where he served meals, alone and away let to we we served heir dring ar a. It 2:41 p.r. is size of the lining room near his lo staff interacted with R6 until to of the dining room towards from at 2:44 p.m. When 10/15, at 12:41 p.m. the AD dion barrier. On 12/20/15, at 3:36 p.m. bey were unable to he resident and had not native method, and said it was A said R6's family visited	2 830	SED		

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If continuation sheet 41 of 61

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00731	B. WING		12/3	1/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE 56 ON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 40	2 830			
	returned to his room wandered. The DO informed the reside a bare mattress, lin bed, and no pillowc agreed staffs' interv	R6 should not have been n or put into bed when he N stated, "That's sad" when ent had been put into bed with en pushed to the end of the ase on the pillow. The DON ventions and/or lack of intions was concerning.				
	director of nursing of system to educate structure system to ensure structure providing cares as of residents. The discould monitor for comedical records. The discould monitor for comedical records.	THOD OF CORRECTION: The or designee could develop a staff and develop a monitoring taff are monitoring and necessary to meet the needs lire constraint of the needs or pliance the ugh audit of the needs audit of the needs are ed at the collarterly QA& \text{\text{A}}	15	SED		
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
2 965	MN Rule 4658.0600 -Nutritional Status	Subp. 2 Dietary Service	2 965			2/8/16
	must ensure that a which supplies the determined by the dassessment. Subs	resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food				
	by:	ent is not met as evidenced on, interview and document		Completion Date: 2-8-16		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/31/2015	
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 41	2 965			
	were implemented	ailed to ensure interventions to prevent significant weight ents (R28) reviewed for				
	Findings include:					
		ler sheet dated 7/1/15, including stroke, chronic dementia.				
	12/11/15 revealed F the past month or 1 residents current we eating problems. The had experienced a	num Data Set (MDS), dated R28 had a weight loss of 5% in 0% in the past 6 months. The email 50# records agorine MDS firth ridentifier R28 wight ossic 20# pount (lb MI Sidate 19/ 6/15, of a	15			
	R28 as having pote to dementia and de Interventions listed residents meals, more port any changes residents weights a	include: staff assist to set up onitor the residents intake and to the physician, monitor the nd report to the physician any ss and allow the resident time				
		g of weights revealed a 20 lb 0 lbs. between 9/15 and 12/15				
	10/14/15 indicates t 170#. The resident	itional assessment dated the residents weight was at eats an average 75-100% of a regular diet with no chewing ems.				

Minnesota Department of Health

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00731	B. WING		10/2	1/201 <i>E</i>
NAME OF				OTATE 710 0005	12/3	1/2015
	PROVIDER OR SUPPLIER		NINTH AVE	STATE, ZIP CODE NUE		
VALLEY	VIEW MANOR HCC		ΓΟΝ, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 42	2 965			
	dated 12/14/15, wit indicates the reside and has not decline weight loss of 20# i risk for malnutrition documented related interventions related. Review of R28's diamonths revealed in	ni nutritional assessment h a significant change ents food intakes are stable ed. The resident is showing a n the past 3 months and is at . No other information was d to causal factors nor d to the weight loss. etary intakes for the previous 3 takes ranging from 0-100% at				
	The residents food	ly intake of food is 25-50%. intake log revealed the reased decline in eating for 5 10 12 15.				
	completed by the d the resident's signif related to the reside requiring more assi	c star, orogi so note, ie cian c 12 15/15, indicc is d icant weigh loss may be ents increased dementia and stance with setting up his endations were provided.				
	12/29/15 at 2:00 p.i of who was respons weights, but confirm most current MDS a triggered/identified The DD stated R28 discussed with the	th the dietary director (DD) on m., indicated she was unsure sible for monitoring R28's ned she had completed the assessment which R28's significant weight loss. 's weight loss had been registered dietician (RD) on D did not provide any				
	12/30/15, at 8:00 a. resident his meal. This meal but did no The resident received.	s of R28 eating breakfast on m. staff were feeding the The resident consumed 90% of t participate in the process. Yed a regular mechanical soft g or swallowing problems.				

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/3	1/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	12/5	71/2013
			NINTH AVE			
VALLEY	VIEW MANOR HCC	LAMBERT	ON, MN 56	152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROID DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 43	2 965			
	at 8:00 a.m. she co R28's significant we nursing staff indicat probably due to his more assistance wi included she did no intervention nor recloss due to the residuency within normal stated she was not weight loss if they follow up the following questioned, the RD weight loss should staff for causal factorinterventions.	th the facility RD on 12/30/15, nfirmed she was aware of eight loss and stated the ted R28's weight loss was dementia and he required the eating. The RD further of the recommend any type of commendation for R28's weight dents body mass index (BMI) I ranges. The RD further concerned about a residents all within their BMI, but may ing month. When further the best at dressed by the of all rollow up		SED		
	director of nursing of revise current policity weight loss and restrictor of nursing of responsible staff on audit to ensure all of being carried out with The director of nursing audits for compliance assurance committee.	or designee could review and ies and procedures related to idents nutritionally at risk. The or designee could educate a the policy changes as well as current recommendations are ithin the dietary department. Sing or designee could conduct ce and review with the quality				
21435	Recreation Program		21435			2/8/16
		al requirements. A nursing				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		00731	B. WING			10/2	1/2015
NAME OF				747E 710 000E		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER		NINTH AVE	STATE, ZIP CODE			
VALLEY	VIEW MANOR HCC		ON, MN 56	-			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION TIVE ACTION SHOUL CED TO THE APPROI FICIENCY)	D BE	(X5) COMPLETE DATE
21435	recreation programs based on each individed strengths, and need meet the physical, right well-being of each right comprehensive resistant and developments and developments and developments and developments and developments. This MN Requirements and developments and developments and developments and developments and developments. This MN Requirements are the facility factorial and the facility diagnoses including disturbance, cognitic chronic obstructive muscle weakness a facility diagnosis repeated impaired cognition is significantly intruded physical behavior to behavior not directed less than daily. The neither the resident could complete the portion of the assessing the factorial and the factorial an	The program must be vidual resident's interests, its, and must be designed to mental, and psychological esident, as determined by the dent assessment and of care required in parts 68.0405. Residents must be its to participate in the opment of the activity and it is not met as evidenced on, interest was and document if the facility on 9/5/14, with a dementia without behavioral we communication deficit, pulmonary disease (COPD), and difficulty walking per the port.	21435	Com etion Dat : 2			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
(V4) ID	STIMMA DV STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	- NI	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
21435	Continued From pa	ge 45	21435			
	between meals, sta or significant other discussions, listenir outdoors.	ng to music and spending time				
	dated 10/4/15, indic R6's son from the p assessment identifi participation in inter specific interest with rides, visiting in per walks/bicycling. Th	ation/Wellness Assessment cated information was given by previous assessment. The ed current interests as: group regeneration programs with a school kids singing, golf cart son/on phone with family, he assessment also included in account with samp on V and es				
	indicated the reside but occasionally ne structuring leisure a wellness. Intervent plan: (1.) CD player in rocresident's desire.	c vities 'ate 10/12/15, ent was primarily independent eded some guidance with activities that promote ions identified on the care om; please play music per Ilness preferences include:				
	exercise, listening t wrestling and war n sensory and 1:1 tim (3.) EMOTIONAL: (individual music en (4.) PHYSICAL: En Well-Fit program to individual cardio. T	o music, watching TV (enjoys novies) food related activities, ne. Offer ipod or CD player for				
	8:50 a.m. the direct	on 12/29/15, at approximately or of nursing (DON) confirmed or understand English. DON				

wiinnesc	<u>ita Department of He</u>	ailli				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
		00731	B. WING	· · · · · · · · · · · · · · · · · · ·	12/3	1/2015
NAME OF I		OTDEET AD	DDEOO OITY (OTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
	I		TON, MN 56			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
21435	Continued From pa	ae 46	21435			
	-					
		aff communicated with the				ı
	resident through ge	stures and facial expressions.				ı
	Continuous observa	ations of R6 on 12/29/15, from				1
		p.m., revealed the following:				ı
	•					ı
		as ambulated with the				ı
		taff, a 3rd staff pushed the				1
		ir (w/c) behind him down the				ı
		ay. Staff were responding in izations. After R6 ambulated				1
		Il staff seated him back in the				1
		ansfer belt and transferred				
		area located by the nurses'				
		d ron to the vision				1
		le hims/ f ir :he w/c				
	throughout the dayr	70 III.				ı
	A+ 1.07 a ma muma:	n anciet t				1
		ny assistant (NA)-A prought sensory item which consisted				ı
		hollow tubes held together				ı
		ord. This enabled the object to				1
		anipulated. R6 accepted the				ı
		id constantly. Although R6				
		d not appear interested nor did				ı
		oulate or pull the sensory item.				ı
		after the item was delivered to the commons area until 1:44				ı
		d practical nurse (LPN)-C				ı
	assisted him back t					ı
		ft his room via the w/c to				
		plastic mug from the drinking				
		the west hallway. Staff				
		ne task, replaced the lid and				
		a water-filled mug, R6				
		ze as he propelled the w/c way. It was noted that once R6				
		of the hallway, staff intercepted				

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and returned him back to his room.

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00731	B. WING		12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 47	21435			
	top of covers with s given to him earlier was not touching not though he appeared time, a popcorn an in the activity room, to attend. At 2:14 p distribute fresh wate immediately. -At 2:30 p.m., R6 w bed in room with the a shoe on his lap, resensory object was music was playing i 4:17 p.m., R6 was or remove and replace Although coffee soo games activities we this time, R6 was neattend. At 3:10 p.m. greeted R6. Traine also entered the roos still "working on his whether R6 was su TMA-A responded the and on R6, they could and on R6, they could and not worry about assist R6. Observations of R6 following: - At 7:50 a.m. R6 w table in the corner of breakfast independ flush to the wall on	as observed lying in bed on hoes on. The sensory item was placed on his legs. R6 or handling the item even d to be wide awake. At this d movie activity was occurring however R6 was not assisted o.m. staff entered the room to er, greeted R6 and left as seated on the edge of his e left shoe off and was holding entering the room. For item is left shoe. The rolonge visualized. Note that it not assisted or offered to enter lace from this left shoe. Stall, wellness group and word are held in the dining room at the assisted or offered to it. NA-C entered the room and difference in the shoe. The hat if NA-C could get it laced all difference in the shoe. The hat if NA-C could get it laced all difference in the dining room eating ently. The table was pushed 2 sides. R6 had his back to in the dining room, facing only item in the dining room in the dining room, facing only item in the dining room in the dining room, facing only item in the dining room in the dining room, facing only item in the dining room in the din				

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	IT OF DEFICIENCIES		(VO) MUUTIDI	E CONSTRUCTION	(V0) DATE	CLIDVEV
_	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:]	: ===
			D WINO			
		00731	B. WING		12/3	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC	200 EAST	NINTH AVE	NUE		
VALLET	VIEW WANDR HCC	LAMBERT	ON, MN 56	152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
	by staff to the Citys table. Staff handed shaped sensory ob when manipulated. without further interbehind him on the sto propel self past t dining room to the results.	m. R6 was assisted in the w/c ide dayroom and placed at a l R6 a multicolored cylinder ject that also made sound Staff then left the area faction. R6 placed the object seat of his w/c and proceeded the nurses' station towards the medication cart where LPN-C -C responded to R6 that he				
	had already eaten a back to his room. L at 8:05 a.m. R6 was bare mattress exported end of bed; no pR6 was observed hattempting to sit up	and assisted in propelling him LPN-C left the resident's room as lying on his bed with the sed and bedding in a clump at bit wear were a till wear and bedding in a clump at bit wear at the sed and bedding in a clump at bit wear at the sed and bedding in a clump at bit wear at the sed and bedding or at t		SED		
	bed and the w/c was the brakes locked. located on the seat was observed ambiguity shoes on and was falong side the wall. administrator who whether R6 was ca ambulation. The adambulate sometime R6 to his w/c. The	s positioned next to bed with R6's tennis shoes were of the w/c. At 8:36 a.m. R6 ulating in his room. R6 had reeling the wall as he walked The surveyor alerted the was walking by to question pable of independent ministrator stated R6 does as observed and redirected administrator asked R6				
	appeared to be breapplied via a nasal left the room. At 8:4 tubing, propelled him w/c and entered an across the hall. -At 10:04 a.m. a ch	his oxygen (02) as he athing heavy. The 02 was cannula and the administrator 19 a.m. R6 removed the 02 mself from the room via the other resident's room located urch activity was conducted in 6 independently propelled				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	himself down the w turned the corned, and propelled him is hallway. R6 then er self around the perilook out the window in the fish tank. R6 direction of the eas near this area until R6 from the east hadayroom. No verbainteraction was note was not offered/assanytime throughout did staff interact with the care with the care and and the corner of the dining resident's as noted. At 2:35 p.m. R6 was where the men's gramin area of the dining resident's as noted. At 2:35 p.m. R6 was where the dining resident's as noted. When interviewed to AD stated R6 is very and is scheduled for further indicated that the corner of the dining resident's as noted.	est hallway but once R6 the administrator redirected back down the direction of the intered the dayroom, propelling imeter of the area, pausing to iv and then watched the activity propelled himself toward the thallway and remained seated 10:30 a.m. LPN-C then moved allway to a table located in the all communication nor ed between staff and R6. R6 sisted to the church activity at the noted observations nor	21435	SED		

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Minnesc	<u>ita Department of He</u>	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/31/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY VIEW MANOR HCC		NINTH AVE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 50	21435			
	stated staff will also well as the men's g 1:1 visits weekly. A language barrier rel and that an interpret to the facility on 12/since. AD stated tri interpreter but calls stated a few weeks another facility cam possible placement to converse with R6 discovered he enjoy. When requested do activities provided finoted: (11/2/15 thrutwo 1:1's with staff (11/16-11/22/15 R6 in the AD indicated sh programming with F6 documentation to dimplemented nor concurred. AD state headphones for R6 language. The AD indicating the Ipod November and 4 till When questioned a (wrestling and war in care plan, she indicipreferences. When were reviewed to sure resident had attend highlighted and/or chad been involved in observations.	offer coffee social time as roup activity as well as three ab confirmed there was a lated to attending activities ater from the high school came 4/15 but had not returned ying to get hold of the had not been returned. AD ago a representative from e to assess the resident for. The representative was able in his native language and yed weaving baskets. On the following was actived to the following was activitied in the following was actived in activity. Although the had provided 1:1 in-room and she was unable to provide the emonstrate this had been ould she recall when this had dishe offered an Ipod with to listen to music in his own then provided documentation was offered 5 times in mes in December 2015. Ibout the preferred activities movies) documented on R6's ated being unaware of these in the current activity sheets ubstantiate the activities each ed, there was nothing documented indicating that R6 in activities during the days of the service of the service and the days of the service activities during the days of the service activities activities activities during the days of the service activities activiti				

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a.m. the AD was unable to provide documentation

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/31/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21435	•	ge 51 in 11/15 and provided 5 days	21435			
	days of documental indicated R6 attend the AD stated he did activity sheets failed					
	R23					
	R23 was admitted on 1/6/15 with diagnoses including: dementia, paranoid personality, mood disorder, and chronic observitive paranoid disease (COPD) per the fact by agnosis report. The report further identity is R23 vas admitted to hospice services on /15/1; due to senile degeneration of the brain.		15	SED		
	assessment dated severely impaired c with locomotion on/	imum Data Set (MDS) 11/6/15, indicated R23 ognition, total dependence off unit, and extensive I mobility, transfer, eating, onal hygiene.				
	5/6/15, indicated ac important to have b to read, very import very important to go when weather is go	ange MDS assessment dated tivity preferences as: very ooks, magazines, newspapers ant to do favorite activities, o outside and get fresh air od, and very important to us services or practices.				
	resident was depen and providing activi stimulation due to c	t revised 11/9/15, indicated the dent on staff for structuring ties that promote wellness ognitive deficits. Interventions 1 bedside/in-room visits and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00731	B. WING		12/31/2015	
	NAME OF PROVIDER OR SUPPLIER VALLEY VIEW MANOR HCC 200 EAS LAMBER			_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21435	activities if [resident of room events. (2) participation in smale interactions (3) EM player for individual ENVIRONMENTAL body language relat [Resident name] Repreferences include word search, TV and R23 was observed from 1:14 p.m. until A popcorn and mov p.m. in the activity ractivity held at 2:30 did not offer R23 thactivity. R23 was again obs 12/30/15, from 10:010.03 a.m. R23 was Cityside dayroom a service was current room. At 10:21 a.m. R23 was Cityside dayroom a service was current room. At 10:21 a.m. R23 was Cityside dayroom a service was current room. At 10:21 a.m. R23 was Cityside dayroom a service was current room. At 10:21 a.m. R23 was cityside dayroom a service was current room. At 10:21 a.m. R23 was cityside dayroom a service was current room.	t name] is unable to attend out a COGNITIVE: Encourage and/or 1:1 IOTIONAL: Offer ipod or CD music enjoyment. (4) is Observe [resident name] ted to over stimulation ecreation/Wellness individual as Bingo, walks, magazines, and listening and playing music." continuously on 12/29/15, 3:56 p.m. while lying in bed. The activity was held at 1:30 in and the concessorial product of the concessoria	21435	SED		

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:		X3) DATE SURVEY COMPLETED		
		00731	B. WING		12/3	1/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC	200 EAST	ORESS, CITY, S NINTH AVE TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	eyes closed while a process. She had reactivition to attend this activition attend this activition attend this activition attend this activition activities. A music activities and NA-A conwith her morning care activities, she oftendown. Both NA's of R23 attendance at R23 had been tearfor receiving care and rather lie down. NA liked to color when church though at tirduring the service. When interviewed of AD stated R23's activities activities activities activities and receiving care and rather lie down. NA liked to color when church though at tirduring the service. When interviewed of AD stated R23's activities activities activities activities and lie attended twice and still expect R to participate in attended to located document and 1:1's provided to sheets indicated R2 times/weekly. AD prom 11/2/15 - 12/5/11/16/15 - 11/22/15	Wellness activity was in not been given the opportunity	21435	SED		

Minnesota Department of Health
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If continuation sheet 55 of 61

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/31/2015		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
VALLEY	VIEW MANOR HCC		NINTH AVE				
(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 SHOUL CROSS-REFERENCED TO THE APPROFINED TO THE	D BE	(X5) COMPLETE DATE	
21435	AD confirmed the 1 and did not identify response. Staff wore effectiveness of plate. When interviewed of AD provided 10 day sheets for R23. The offered activities on unable to provide doffered in November activity sheets for Cosheets did not inclust had participated or confirmed the chart incomplete. SUGGESTED MET activity director couresident's assessed honored, and then a occurring. Results of reviewed at the quarter.	11/27/15, 12/4/15, 12/7/15). :1 charting was inadequate the activity, time and/or ald not be able to evaluate nned interventions. on 12/31/15, at 10:21 a.m. the as of December 2015 activity e sheets indicated R23 was 5 of the 10 days. AD was ocumentation of activities or 2015 and provided 5 days of october 2015. The activity de evidence if the resident of activity here is not activity de evidence if the resident of activity.	21435	BED			
21565	Subp. 4. Self-adm self-administer med resident assessment care as required in 4658.0405 indicate	5 Subp. 4 Administration of dmin inistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.	21565			2/8/16	
	This MN Requireme	ent is not met as evidenced					

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Minnesota Department of Health STATE FORM

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVEY COMPLETED

00731

B. WING ___

12/31/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VALLEY VIEW MANOR HCC		NINTH AVE		
(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		
	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.		Completion Date: 2-8-16	
	Findings include:			
	R6's physician orders dated 12/8/15, included lpratropium-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 Minimur Data et I/IDS) date 1 10/9/15, indicated R6 mac Sever cognitive impairment.		SED	
	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			

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If continuation sheet 56 of 61 ZNOX11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00731	B. WING		12/31/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21565	Continued From pa	ge 56	21565			
	staff present within	visualization of the resident.				
	practical nurse (LPI room. R6 was sittir no longer had the n machine running.	proximately 2:50 p.m. licensed N)-D was observed in R6's ng on the edge of bed though ebulizer mask on nor was the				
	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-					
		rc edure title , Nebulizers nitor the resident ແກວughout				
	Director of Nursing appropriate assess ensure the safe adr The DON could enson the importance of The DON or design resident records to and documentation could random audit left with residents u interdisciplinary tea could then be presemeetings.	THOD OF CORRECTION: The (DON) or designee ensure the ments are conducted to ministration of medications. Sure the staff were educated of the assessment process. He could randomly audit ensure adequate monitoring was in place. The DON could sto ensure medication is not nless deemed safe by the m. Results of these audits ented at the quarterly QA&A				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:) DATE SURVEY COMPLETED		
		00731	B. WING		12/3	1/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC	200 EAST	ORESS, CITY, S NINTH AVE ON, MN 56		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21695 21695	MN Rule 4658.1418 Housekeeping, Ope Subp. 4. Houseke provide housekeepinecessary to mainta comfortable interior ceilings, registers, f and furnishings. This MN Requirement by: Based on observatifialed to ensure 1 or reviewed with floor sheet rock that was Findings include: During observation on 12/31/15, at 8:30 hole approximately sheetrock at the bar is adjacent to the turn During observation at 8:35 a.m. the mathe damaged wall in He stated, "tub has damaged the reside tub room was adjact maintenance direct size hole in the wall dispenser and agree did not create a hor maintenance direct policy/procedure but	of Subp. 4 Plant eration, & Maintenance eping. A nursing home musting and maintenance services ain a clean, orderly, and including walls, floors, ixtures, equipment, lighting, ent is not met as evidenced on and interview the facility for the control of wall do nation and interview the facility for the control of wall do nation and interview the facility for the control of wall do nation and interview on 109 (R6) of a.m. it was noted to have a 15 inches by 4 inches in the se of the bathroom wall which also room. and interview on 12/31/2015, intenance director confirmed in the bathroom of room 109, been leaking and this has ent's wall". He indicated the cent to R6's bathroom. The cort further confirmed a quarter below the toilet paper ed the areas in the bathroom melike environment. The or could not provide a ut indicated staff would fill out a coard when there was a	21695	Completion Date: 2-8-16		2/8/16

Minnesota Department of Health
STATE FORM

PRINTED: 05/10/2016 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ B. WING 00731 12/31/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21695 Continued From page 58 21695 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 guarterly QA&A meetings. TIME PERIOD FOR COLL. TCT CT CT your young (21) days. 21975 MN St. Statute 144A 0 Sut. 1.3 pspection; 2 975 2/8/16 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

Minnesota Department of Health STATE FORM

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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0731

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

200 FAST NINTH AVENUE

FORIVI APPROVEL

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:
B. WING
Technology
12/31/2015

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				
VALLEY	VIEW MANOR HCC	AST NINTH AVE BERTON, MN 56		
(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 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 documer 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 ance all 0 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 bulletine board near the north and south nurses stations but confirmed they were not. After 15 minutes 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 stare. The binder which included the survey results we not visible nor easily accessible to the resident 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 of designee could monitor for continued compliant	ed s, of d. vas s, e	Completion Date: 2-8-16	

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	(X3) DATE COMP	SURVEY LETED		
		00731	B. WING		12/31/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21975	Continued From pa	ge 60	21975			
	•	R CORRECTION: Twenty-one				
		REV		SED		

Minnesota Department of Health STATE FORM

ZNOX11

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: ZNOX

 ${\bf MEDICARE/MEDICAID\ CERTIFICATION\ AND\ TRANSMITTAL}$

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY A	GENCY		Facility ID: 00731
MEDICARE/MEDICAID PROVIDER NO.(L1) 245378	₹	3. NAME AND AD (L3) VALLEY VI					4. TYPE OF ACT	<u> </u>
2. STATE VENDOR OR MEDICAID N (L2) 425340000	O.	(L4) 200 EAST N (L5) LAMBERT		J E	(L6) 5	6152	 Initial Termination Validation 	 Recertification CHOW Complaint
5. EFFECTIVE DATE CHANGE OF OV (L9)	VNERSHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD		02 (L7) 13 PTIP 22 CLIA		7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 2/17/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR EN	DING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	50 (L18) 50 (L17)	Compliance1. A B. Not in Comp	equirements e Based On:	am	2. Techn 3. 24 Ho	ical Personnel our RN RN (Rural SN	7. Medical	Services Limit Director oom Size
14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF 50 (L37) (L38)	N 19 SNF (L39)	ICF (L42)	IID (L43)	Wal (Ors.	15. FACILITY M 1861 (e) (1) or		(L15)	
16. STATE SURVEY AGENCY REMAI	RKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION :	DATE):				
17. SURVEYOR SIGNATURE Tammy Williams, HFE	NE II	Date :	02/24/2016	(L19)	18. STATE SURV		APPROVAL Enforcement Sp	Date: $\begin{array}{c} \text{Date:} \\ \text{ecialist} 02/25/2016 \\ 1.20 \end{array}$
PAR	Г II - ТО ВЕ (COMPLETED I	BY HCFA RI	, ,	C OFFICE OR	SINGLE ST	FATE AGENCY	(LZC
DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to Par 2. Facility is not Eligible			IPLIANCE WITI HTS ACT:	H CIVIL	2. Ov		icial Solvency (HCFA-2 1 Interest Disclosure Str :	
22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24)	23. LTC AGREEN BEGINNING		4. LTC AGREEM ENDING DA		26. TERMINAT VOLUNTARY 01-Merger, Closu 02-Dissatisfaction		05-Fail	(L30) UNTARY to Meet Health/Safety to Meet Agreement
	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involur 04-Other Reason f	-	OTHER	rider Status Change
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
	(L28)	00803		(L31)				
31. RO RECEIPT OF CMS-1539		. DETERMINATION	OF APPROVAL		P.EMES 1 22 - 1		201111	
	(1.32)			(L33)	DETERMINA	ΤΙΟΝ ΔΡΡΡ	2 () \/ Δ I	



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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

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 \$5378029

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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REV	/ISIT
	A. Building B. Wing	,	Y2	2/17/2016	Y3
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).

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix F0		Correction	ID Prefix			Correction
Reg. #	483.10(b)(11)	Completed	Reg. #	3.10(g)(1)	Completed	Reg. #	483.10(n)		Completed
LSC		02/08/2016	LSC		02/08/2016	LSC			02/08/2016
ID Prefix	F0248	Correction	ID Prefix F02	282	Correction	ID Prefix	F0309		Correction
Reg. #	483.15(f)(1)	Completed	Reg. # 483	3.20(k)(3)(ii)	Completed	Reg. #	483.25		Completed
LSC		02/08/2016	LSC		02/08/2016	LSC			02/08/2016
ID Prefix	F0325	Correction	ID Prefix F04	465	Correction	ID Prefix			Correction
Reg. #	483.25(i)	Completed	Reg. # 483	3.70(h)	Completed	Reg. #			Completed
LSC		02/08/2016	LSC		02/08/2016	LSC			
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			
REVIEWI STATE A		REVIEWED BY (INITIALS) GD/kfd	DATE 2/24/2016	SIGNATURE OF	SURVEYOR 2603			DATE 2/17/2	2016
REVIEWI CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOW 12/31/20		Y COMPLETED ON		FOR ANY UNCORRE			IE EA OU IEVO	☐ YE	s 🗆 no

Form CMS - 2567B (09/92) EF (11/06)

Page 1 of 1

EVENT ID:

ZNOX12

		POS1-0	JEKII	FICATIO	N KEVISII I	REPORT			
	DER / SUPPLIER / CLIA / FICATION NUMBER	MULTIPLE CON A. Building 01						DATE OF RE	VISIT
245378	3 _{Y1}	B. Wing					Y2	2/16/2016	Y3
NAME (OF FACILITY				STREET ADDRESS,	CITY, STATE, ZIF	CODE		
VALLE'	Y VIEW MANOR HCC				200 EAST NINTH AVE				
					LAMBERTON, MN 56	152			
prograr correcte provision	port is completed by a c m, to show those deficie ed and the date such co on number and the iden vey report form).	ncies previously prrective action	y reported was accom	on the CMS-256 plished. Each c	 Statement of Deficiency should be f 	ciencies and Pla ully identified us	an of Correct sing either th	ion, that have ne regulation	e been or LSC
ITI	EM	DATE	ITEM	1	DATE	ITEM		DA	TE
Y	4	Y5	Y4		Y5	Y4		Y	′ 5
ID Prefix	×	Correction	ID Prefix		Correction	ID Prefix		Cor	rection
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #		Con	npleted
LSC	K0025	01/04/2016	LSC	K0038	01/06/2016	LSC			
ID Prefix	×	Correction	ID Prefix		Correction	ID Prefix		Cor	rection
Reg. #		Completed	Reg. #		Completed	Reg. #		Con	npleted
LSC		_	LSC			LSC			
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REVIEWED BY **REVIEWED BY** DATE SIGNATURE OF SURVEYOR DATE (INITIALS) TL/kfd STATE AGENCY 2/24/2016 35482 2/16/2016 DATE TITLE DATE **REVIEWED BY REVIEWED BY CMS RO** (INITIALS) **FOLLOWUP TO SURVEY COMPLETED ON** ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

Completed

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

Reg. #

LSC

Form CMS - 2567B (09/92) EF (11/06)

Reg. #

12/29/2015

LSC

Completed

Reg. #

LSC

Page 1 of 1

EVENT ID:

ZNOX22

☐ YES ☐ NO

Completed



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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

				STAT	E FOR	RM: RE\	/ISIT	REPORT				
	ER / SUPPLIER CATION NUMB		MULTIPLE CON A. Building	ISTRUCTIC	N						DATE (OF REVISIT
00731	CATION NOWD	LN Y1	B. Wing							Y2	2/17/20	016 _{Y3}
	FACILITY							ET ADDRESS, C		, ZIP CODE		
VALLEY	VIEW MANOI	RHCC						AST NINTH AVE ERTON, MN 561				
This rop	art is complete	nd by a S	tata curvovor to	show that	o dofio	ionoios pr		· · · · · · · · · · · · · · · · · · ·		n corrected and	the dat	o such
correctiv	e action was a ation prefix cod	ccompli	shed. Each def	iciency sho	ould be	fully ident	ified us	sing either the	regulation	or LSC provisio ach requirement	n numbe	er and the
ITE	М		DATE	ITEM				DATE	ITEM			DATE
Y4			Y5	Y4				Y5	Y4			Y5
ID Prefix	20265		Correction	ID Prefix	20302			Correction	ID Prefix	20565		Correction
Reg. #	MN Rule 4658.	0085	Completed	Reg. #	MN Sta 144.650	ite Statute 03		Completed	Reg. #	MN Rule 4658.04 Subp. 3	405	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. Subp. 1	0520	- Completed	Reg. #	MN Rul Subp. 2	e 4658.060	00	Completed	Reg. #	MN Rule 4658.09 Subp. 1	900	Completed
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REVIEWI CMS RO	ED BY	REVIE\	WED BY LS)	DATE		TITLE					DATE	

Page 1 of 1 EVENT ID: ZNOX12

YES NO

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

12/31/2015

FOLLOWUP TO SURVEY COMPLETED ON

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: ZNOX

 ${\bf MEDICARE/MEDICAID\ CERTIFICATION\ AND\ TRANSMITTAL}$

PAR	RI I - IO BE COMPI	LETED BY THE	E STATE SUI	XVE I AGENC I	Facility ID: 00/31
MEDICARE/MEDICAID PROVIDER NO.(L1) 245378	(L3) VALLEY VI	DDRESS OF FACILITIEW MANOR HC			4. TYPE OF ACTION: <u>2 (</u> L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAID NO. (L2) 425340000	(L4) 200 EAST N (L5) LAMBERT ((L6) 56152	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWNERSHII (L9)	01 Hospital		ESRD 13 PT	` ′	8. Full Survey After Complaint
6. DATE OF SURVEY 12/31/2015 (L 8. ACCREDITATION STATUS: (L 0 Unaccredited		07 X-Ray 11	ONF 14 CC 1 ICF/IID 15 AS 2 RHC 16 HC		FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 50 (L 13. Total Certified Beds 50 (L	A. In Complia Program Re Compliance	equirements e Based On: .cceptable POC npliance with Program	_ _ _ _	Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
50	Requirements SNF ICF (L42)	and/or Applied Waive	15. FA	: B* CILITY MEETS (e) (1) or 1861 (j) (1):	(L12) (L15)
16. STATE SURVEY AGENCY REMARKS (IF AF		, ,	E):		
17. SURVEYOR SIGNATURE	Date :		18. ST.	ATE SURVEY AGENCY	Y APPROVAL Date:
Lois Boerboom, HFE NE II		02/03/2016	(L19) Kama	ala Fiske-Downing	g, <u>Enforcement</u> Specialist _{02/24/2016}
PART II - TO	BE COMPLETED I	BY HCFA REGI	ONAL OFFI	CE OR SINGLE S	STATE AGENCY
DETERMINATION OF ELIGIBILITY		MPLIANCE WITH CIV HTS ACT:	VIL 2		ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) re:
	GREEMENT 24 NNING DATE	4. LTC AGREEMEN' ENDING DATE (L25)	VOLUM 01-Mer	ERMINATION ACTION NTARY ger, Closure satisfaction W/ Reimburs	0 INVOLUNTARY 05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: 27. ALTEI A. Sus	RNATIVE SANCTIONS spension of Admissions: cind Suspension Date:	(L44) (L45)		s of Involuntary Terminatic er Reason for Withdrawal	OTHER
28. TERMINATION DATE:	29. INTERMEDIARY/		30. RE	MARKS	
	00803				
(L28)		(1	(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMINATION	N OF APPROVAL DAT	TE		
(L32)		(1	(L33) DETE	ERMINATION APP	PROVAL



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 \$5378029

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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Valley View Manor Hcc January 20, 2016 Page 2

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

Valley View Manor Hcc January 20, 2016 Page 4

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

Valley View Manor Hcc January 20, 2016 Page 5

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

Kamala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 02/04/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY IPLETED
		245378	B. WING			12/	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE _AMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ΓS	F C	000			
	as your allegation on Department's accept enrolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.					
F 157 SS=G	on-site revisit of you validate that substa regulations has bee your verification. 483.10(b)(11) NOT		F 1	157			2/8/16
	consult with the resknown, notify the reor an interested fan accident involving the injury and has the printervention; a signiphysical, mental, or deterioration in heastatus in either life to clinical complication significantly (i.e., a existing form of treatment); or a decithe resident from the §483.12(a).	ediately inform the resident; ident's physician; and if esident's legal representative mily member when there is an the resident which results in cotential for requiring physician if ident change in the resident's respective psychosocial status (i.e., a lith, mental, or psychosocial threatening conditions or eas); a need to alter treatment need to discontinue an eatment due to adverse to commence a new form of cision to transfer or discharge the facility as specified in					
	and, if known, the roor interested family	so promptly notify the resident esident's legal representative member when there is a					
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		SURVEY PLETED
		245378	B. WING		12/3	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC		2	STREET ADDRESS, CITY, STATE, ZIP CODE 100 EAST NINTH AVENUE LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	change in room or specified in §483.1 resident rights under regulations as specifies section. The facility must rethe address and phased on interview facility failed to not manner for 2 of 4 refor hospitalization with changes in conditionand vomiting, related notification and substitutional the section of the section and substitutional facility for Findings include: R46's discharge or dated 9/17/15, identification and the section of th	roommate assignment as 15(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of cord and periodically update none number of the resident's er or interested family member. NT is not met as evidenced and document review, the fighth physician in a timely esidents (R46, R21) reviewed who experienced significant for requiring medical treatment. The fighth physician is a timely esident of the resident of the resident of the resident of the requiring medical treatment. The requiring medical treatment is a small bowel obstruction. In the resident of the resident of the resident of the sis, and urinary tract infection. The regress note also identified a discharge condition of the sis, and urinary tract infection.	F 157	The preparation of the following pleorrection for this deficiency does reconstitute and should not be interplated as an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statemed eficiencies. The plan of correction prepared for this deficiency was exsolely because provisions of state a federal law require it. Without waive foregoing statement, the facility stawith respect to: 1. Resident #21 s physician has updated on a regular basis on the changes in her condition and overa status. Resident #46 is deceased. 2. All resident s were reviewed for change in condition and need to not physician per phone call. All reside orders for insulin were reviewed an corrected where orders to call the physician for high glucose readings standing orders were updated per recommendation of our medical direction to notify the physician if two Blood Glucose results are <70 or >400 in	not reted by the ed or ent of necuted and ring the tes been all or any otify the ent id.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		245378	B. WING		12/31	1/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	area assessments R46's care plan, da cognitive impairmer return to the comm R46's September 2 revealed R46 had r 30 cubic centimeter four times on that c 2:00 a.m. on 9/26/1 licensed practical in the medication administered on 9/2 the medication had since supper. No freeffectiveness was centry dated 9/26/15 had received anoth stomach and emes listed as had anoth the other doses addresults documented. A nursing progress 9/25/15 at 8:30 a.m. and complaints of rindicated R46 had lalong with Thorazir after his morning mhad experienced a the bed and himsel anything for breakfa orange juice that had A nursing progress	15 (cognitively intact). No care were completed with the MDS. ted 9/30/15 identified no nots and that R46 desired to unity. 015 medication sheets eceived Maalox (an antacid) at (cc)'s on 9/25/15 a total of late, as well as one dose at 5. Notations documented by urse (LPN)-A, on the back of inistration record for a dose 25/15, at 2:00 a.m. indicated been given for stomach upset collow up assessment for completed. A subsequent at 2:00 am. indicated R46 er dose of Maalox for an upset is; the follow up result was er emesis at 4 a.m. None of ministered had follow up d. Inote written by LPN-F on an indicated R46 had hiccups not feeling well. The notes one given Maalox 30 cc's are and had begun retching ledications. In addition, R46 large projectile emesis all over af, and had refused to eat last, stating he had consumed and all come up.	F 157	hour period. 3. Education to licensed staff will completed by 2-3-16 on ensuring the physicians are notified in a timely reconcerning any resident change in condition and that physician orders obtained for elevated glucose leve including orders to call the physiciathere is two blood Glucose results >400 in a 24 hour period. 4. When residents present with a change of condition nurses will cal physician immediately (within a timmanner) and notify the Director of instead of using fax. Physician orders to call the physiciathere is two blood glucose results >400 in a 24 hour period. 5. The DNS or designee will comaudits weekly for 4 weeks and wee 2 months to ensure that the facilitie line is being followed correctly. 6. The data collected will be reviewed/discussed at the quarterl meeting. At this time the QA&A committee will make the decision/recommendation regarding follow-up studies. The DNS will be responsible for the Completion Date: 2-8-16 Valley View Manor Plans to IDR Faces and the part of the completion Date: 2-8-16	hat manner s are ls, an when <70 or I the nely Nursing ders are ls, an when <70 or plete 2 ekly for es guide y QA&A ng any is POC.	
		p.m. indicated R46 had a hat the resident had stated he				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245378	B. WING		12	/31/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 200 EAST NINTH AVENUE LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	hiccups had subsic started again. Door received Maalox armedication used for another small eme documented as har and was described R46's temperature been elevated at 9th A nursing progress p.m. per LPN-F incommost of the evening hiccups were better but that R46 had be feel right and that we to gag. R46 had expressed by the sips of water. Additing the sips of water. Additing temperature at 99.5 feeling chilly. A nursing progress p.m. per LPN-F incomplete in the sips of water. Additing temperature at 99.5 feeling chilly. A nursing progress p.m. per LPN-F incomplete in the sips of water at 99.5 feeling chilly. A nursing progress p.m. per LPN-F incomplete in the sips of water at 99.5 feeling well, and have a feeling well, and have a feeling well in the sips of water to have a feeling well in the sips of	age 3 II. The notes indicated his ded for a while but had then sumentation indicated R46 had and Thorazine (an antipsychotic or antiemetic properties) with sis afterward. The emesis was ving had food particles present as having a colicky odor. was documented as having 9.0 degrees Fahrenheit (F). note dated 9/25/15, at 6:00 dicated R46 had stayed in bed g. The note indicated R46's rover the early evening hours een stated his tummy still didn't whenever he moved he began aten Jell-O for supper and had tionally, the documentation esimile) had been sent to 20-A with an update on R46's that R46 had an elevated 5 degrees F and complained of the dated 9/25/15, at 11:05 dicated R46 had not been and been having brown colored e afternoon shift which did not excess odor. Maalox 30 cc's had with hiccups and R46's held due to emesis. note by LPN-A, dated 9/26/15, ted R46's abdomen was el sounds were difficult to hear aving emesis which looked like as noted to be slightly elevated	F1	57		

AND PLAN OF CC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SUF				
		245378	B. WING _		12/31/2	015			
	IDER OR SUPPLIER W MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	0 EAST NINTH AVENUE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COM	(X5) IPLETION DATE			
A n 9/2 of 6 mo ind slig R4 cor A n 9/2 furt of I an ord em ind agr fac A fi pre ord hos An 9/2 adr dia sur A fi p.n ide exp thru drir	additional nursing additional nursing progress of the total transfer personal to the day and the day a	note written by LPN-A on m. indicated R46 had 100 cc's formed/loose BM (bowel odor. The note further cool and clammy, with a mperature at 99.1 degrees F. asket beside him, and n. note entered by LPN-B, dated m. indicated R46 had two reenish liquid thick with pieces In addition, the note indicated oital had been called and an to transfer R46 to their ER) via ambulance. The note ughter was updated and had not the transportal of the cool of the coo	F 15	57					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED		
		245378	B. WING _		12	/31/2015		
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP COI 200 EAST NINTH AVENUE LAMBERTON, MN 56152				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 157	responded with a stelephone order to Please do NOT fax need attn [attention [physician] - today staing for response. The ER progress name was reviewed had appeared distribeen uncomfortable with dried brown m. The ER note furthe was firm and diffus with no appreciable 1800 milliliters (ml) drained from R46's a nasogastric tube normal saline intravious physician's note included dehydrated and diagnoses of small dehydration. The ER registered 9/26/15, at 11:17 and he'd been vomiting emesis was now brownited three times the ER and the von brown liquid running abdomen was very and the abdomen	e nurse practitioner (NP)-A tatement including, "Noting transfer to ER on 9/26/15. In regard to situations that of that day. This will be sent to 9/28/15. Please review the procedure. Thx [Thanks]." ote dated 9/26/15, at 10:36. The ER note indicated R46 essed when examined, had e, and had dry oral mucous aterial on the tongue and lips. In indicated R46's abdomental ely distended, mildly tender ely distended, mildly tender ely distended, mildly tender ely distended, mildly tender ely distended and preceived 2000 ml of venous for hydration. The ER dicated R46 had appeared and verified the admitting bowel obstruction and severe the insertion of R46 had stated for the last two days and his rown like stool. R46 had stated for the last two days and his rown like stool. R46 had sin the ambulance enroute to nit was described as dark gout of his mouth. R46's firm, with no bowel sounds was distended. R46 ominal pain but was unable to had his stomach drained via a or ten minutes with 1400 mL of nich R46 stated he felt much ert and "states we should do	F 15	57				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY MPLETED
		245378	B. WING		12/	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	The hospital dischaindicated R46 had to correct the small developed subsequanticoagulation issuileus (disruption in surgery. The ileus of a nasogastric tub were initiated and F During interview on director of nursing expected staff to commediately with the specially when the BM-type material a During interview on nursing home's heacoordinator/nursing LPN-B was not well hospital intensive conterview. The HIM pool nursing staff. During interview on acting administrato the time of the incider R46's family had in hospital with a bow later been found to administrator was a regarding R46's epstated she would had contact/call the ondirectly with concertions.	to do. Is comfortable now." arge summary dated 10/5/15, undergone abdominal surgery bowel obstruction, and had lent cardiac and less as well as post-operative normal bowel motility) after the resolved with the replacement be; however, comfort cares R46 passed away on 10/5/15. 12/29/15, at 3:07 p.m. the (DON) verified she would have ontact the on-call doctor e urgent clinical issues, e resident was vomiting and not feeling better.	F 15	7		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245378	B. WING		12/3	31/2015		
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW MANOR HCC			2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	12/31/2015			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 157	status, appetite and a physical assessm she thought LPN-A her judgment. She every Thursday nig When LPN-A was i on 12/29/15 at 4:02 received report from on 9/25/15, regardi been unaware a fastated she'd worker prior and was awar complaints of not feel She was aware R4 been eating well, an administered Maalox first time she admir LPN-A verified R46 like stool but there abdomen had also LPN-A was unawar complained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subsequently vomit later in her shift (an she'd become concomplained of pain subs	ital signs, bowel movement of fever status while conducting thent. The administrator stated was a good nurse and trusted further verified LPN-A worked that shift. Interviewed about the incident of p.m., LPN-A stated she'd of the evening nurse (LPN-F) of R46's emesis, but had of the had been sent. LPN-A of with R46 at least one time of R46's vomiting and of the eling well was new for R46. The had thrown up and had not not had subsequently of the had subsequently of the had subsequently of the had helped somewhat the histered it (around 2:00 a.m.). The had emesis of what looked was no odor. She verified his seemed a little distended. The whether R46 had	F 157					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245378	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 157	pass along to the day of the day of the physicial symptoms, and that there had been a day physician notification. During interview on medical director was would have expected they filled out the past the hospital. The malthough R46 may hanyway, prompt me him comfortable. The effect of delayed may related to R46's me state since she was buring interview on medical doctor (MD stated he would have called the clinic and R46 began vomiting stated faxing medical p.m. was inappropring the them to the delay in after his symptoms made some "depresent hospital transfer on were a "sidebar" and issue. MD-A confirmation of the delay in a state. MD-A confirmation is the master of the delay in a state. MD-A confirmation is the master of the delay in a state. MD-A confirmation.	n filling out the paperwork to ay shift personnel. Interview on 12/30/15, at 9:12 tor stated LPN-A should have an sooner about R46's t she had not been aware elay in his nursing care and	F 1	57			

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245378	B. WING			12/	31/2015
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW MANOR HCC			,	20	REET ADDRESS, CITY, STATE, ZIP CODE NO EAST NINTH AVENUE AMBERTON, MN 56152	<u>,</u>	<i></i>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	vomiting brown studyou are seen." The facility's policy SBAR last revised 3 notification of the playmptom, sign or a sudden in onset, a severe) in relation thank was unrelieved prescribed. The posection related to a immediate notification required when there of marked tendernet (gastrointestinal) bl	MD-A stated, "when you are if, it is probably a good idea if entitled Change in Condition 3/15, indicated immediate hysician was required for any pparent discomfort that was marked change (i.e. more o usual signs and symptoms by measures already slicy further indicated in a bdominal distension that on of the physician was e was rapid onset, or presence ess, fever, vomiting or GI eeding.	F 1	57			
	Record (MAR) date that blood sugar (B five (5) times per da - 12/29/15 there we which were docume deciliter (dL) and at documented BS lev mg/dL. Although the fluctuated dramatic physician notification registered greater to A physician's order Insulin Regular Hur (ml) Inject as per slordered dosage "grunits".	edication Administration and December 2015, identified S) readings were monitored ay. Between the dates of 12/1 are 44 blood sugar (BS) levels ented as 400 milligrams (mg)/200ve, with 25 of those are readings higher than 430 are resident's blood sugars ally, there had not been an of blood sugars which than 430 mg/dL. dated 11/3/15 indicated, man Solution 100 unit/milliliter iding scale with the final eater than 400 mg/dL: give 6					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245378	B. WING			12/31/2015		
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW MANOR HCC				STREET ADDRESS, CITY, STATE, ZI 200 EAST NINTH AVENUE LAMBERTON, MN 56152	P CODE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD HE APPROPF	ON SHOULD BE IE APPROPRIATE		
F 157	subcutaneous (SQ) sliding scale with R unit/ml. BS reading diabetic educator w listed for notification hypo (low) or hyper During interview on licensed practical n were no protocols, notify the medical dLPN-C stated she whow the resident fe BS-which she ident 500's". On 12/30/15, at 2:3 would notify the MD above 600 mg/dL. 12/29/15, the supper mg/dL and the MD further stated R21 fabove 400 mg/dL aread to give 6 units was greater than 35 when the glucometro fa BS over 600 m the nurse on call at reading. During interview on diabetic educator in reports of R21's BS the clinic has a protadjustments and th were based upon. stated R21 had a himself.	ge 10 lution 100 unit/ml- 24 units one time per day (QD), and egular Humalog solution 100 gs were to be faxed to the reekly. No parameters were of the physician regarding (high) glycemia (BS). 12/30/15, at 3:10 p.m. a urse (LPN)-C indicated there or orders, indicating when to loctor (MD) of BS levels. vould notify the MD related to lit and if there was a high ified as "way above 400's- 6 p.m. LPN-D stated she of she obtained a BS result LPN-D confirmed on er BS check for R21 was 521 was not updated. LPN-D requently has BS readings and the facility standing orders of regular insulin if the BS on mg/dL. LPN-D indicated er read "high" it was the result g/dL and she would telephone the hospital to report the 12/30/15, at 2:57 p.m. the dicated she received weekly be results. She further stated cocol for diabetic medication is was what insulin changes The diabetic educator further listory of being a brittle diabetic ere supposed to call the	F 1	57				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245378	B. WING _		12	/31/2015
	PROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CO 200 EAST NINTH AVENUE LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	related to changes educator further inc parameters had be recently discharged 12/5/15. She indichave been determing the been determing interview or and RN-C stated the for reporting BS redocumentation on and stated that wor followed unless incompared witten. RN-B indicated that wor followed unless incompared with the standard RN-C indicated Change in Condition reporting of BS rear RN-B stated, "we were veryone is aware." During interview or indicated she had be a months at the factor on BS checks which area, wear gloves, resident had orders specific insulin order specific insulin order in the recheck in the whether the BS was stated she would put this instance as this	in call and/or the triage nurse in status. The diabetic dicated she thought BS is incentified when R21 was different the hospital on ated the parameters would need by the discharging MD. In 12/30/15, at 3:12 p.m. RN-B is incentified when a state of the discharging MD. In 12/30/15, at 3:12 p.m. RN-B is incentified when a state of the facility's standing orders and be the practice they dividualized orders were stated if a resident was would notify the physician ling order instructions. RN -B did they were not aware of the on policy related to immediate dings above 430 mg/DL. will have to make certain	F 15	57		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTIO			E SURVEY MPLETED
		245378	B. WING			12	/31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS 200 EAST NINTH LAMBERTON, I	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	IDER'S PLAN OF CORRECT ORRECTIVE ACTION SHOU FERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 157	she would do. On 12/31/15, at 9:0 the facility's medicaresident would have from the hospital for physician stated R2 before admission to history of blood sugthat the resident was when her blood sughowever, stated if so for an elevated blood provide specific orderequired to recheck results. She stated, 'hi' because they have blood sugar is below to initiate the hypogindicated she would and/or on-call staff were outside range. When interviewed of director of nursing (2015 documentation indicated she was not of BS readings for larged. She confirm staff to notify the at staff in accordance when to Report to The facility's policy notification for blood Change in Condition MD/nurse practition.	4 a.m. R21's physician, also al director, stated typically a e a specific order that comes r sliding scale insulin. R21's at had been her patient even to the nursing home, and had a pars fluctuating "all over" but as usually most comfortable pars ran over 300 mg/dl. She'd received a telephone call and sugar level she could lers as to when staff were the BS and call back the "they call if the meter reads ave nothing to base it off. If the w 70 mg/dL staff would need allycemia protocol." She further the expect staff to notify the clinic to update on BS readings that		57			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ATE SURVEY DMPLETED
		245378	B. WING	l 1	2/31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE AMBERTON, MN 56152	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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		ge 13 machine registers high) in ing sliding scale insulin should	F 157		
F 167 SS=C	practitioner (NP)."	orted to the physician or nurse TTO SURVEY RESULTS - IBLE	F 167		2/8/16
	the most recent sur Federal or State su correction in effect The facility must ma examination and m	ight to examine the results of vey of the facility conducted by rveyors and any plan of with respect to the facility. ake the results available for ust post in a place readily ents and must post a notice of			
	by: Based on observat review the facility fa current survey resu readily accessible to visitors. This had th residents currently Findings include: During the initial too director of nursing (p.m., observations and state survey re residents, families of the results are usua board near the nort	ion, interview, and document illed to ensure the most lits were posted in an area or residents, families and e potential to affect all 40 residing in the facility. For of the facility with the DON) on 12/28/15, at 12:00 revealed the current federal sults were not available to or visitors. The DON indicated ally posted on the bulletin h and south nurses stations, were not in that location. After		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 th 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 execute 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 with have access to the most current survey	d e

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY
		245378	B. WING _		12/3	1/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 167	DON found them to behind the south nu chart stand. The bir results was not visit	ge 14 ng for the survey results, the be in a 3- ring binder placed urses station in the resident nder which included the survey ble nor easily accessible to the or visitors. The DON	F 16	results. 3. Education will be completed by 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 are posted in the designated location. The Administrator or designated location. The Administrator will be reviewed/discussed at the facilities of correction is being followed. 5. The data collected will be reviewed/discussed at the quarterly meeting. At that time the QA&A committee will make the decision/recommendation regarding follow-up studies. The Administrator will be responsible this POC.	sults esults. will y d gnee 1 eek for s plan v QA&A	
F 176 SS=D	DRUGS IF DEEME An individual reside the interdisciplinary §483.20(d)(2)(ii), ha practice is safe.	ent may self-administer drugs if team, as defined by as determined that this	F 17	Completion date: 2-8-16		2/8/16
	by: Based on observat review the facility fa	NT is not met as evidenced ion, interview, and document illed to ensure the safe inistration for 1 of 2 residents		The preparation of the following place correction for this deficiency does reconstitute and should not be interpreted to the constitute and should not be also should not be also should not be a should not b	not	

PRINTED: 02/04/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245378	B. WING		12/	31/2015	
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		31/2015	
	VIEW MANOR HCC			200 EAST NINTH AVENUE	_		
				LAMBERTON, MN 56152			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHORES (CROSS-REFERENCED TO THE APIDEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 176	rebulizer treatment Findings include: R6's physician order Ipratropium-Albuter milligrams/3 millilite times a day for showhile awake. R6's annual Minimu 10/9/15, indicated Fimpairment. Review of R6's care a risk for alteration (r/t) diagnoses of eleobstructive pulmonacute episode. His h/o bronchospasms muscles in the walls difficulty breathing) identified a behavior included routinely retreatments. Further review of the include evidence of R6's ability to self-at On 12/29/15, at 2:3 observed R6 sitting wearing a nebulizer and medication not receptacle. R6 was staff present within	erved self- administering a	F 1	as an admission nor an agreed facility of the truth of the facts conclusions set forth in the state deficiencies. The plan of corresprepared for this deficiency was solely because provisions of sederal law require it. Without foregoing statement, the facilit with respect to: 1. Resident # 6 was transfer another facility on 1-25-16. 2. All residents for whom ne treatments are ordered have be reviewed to ensure that nursin remaining with them during the treatments. 3. Education will be completed for all Licensed Nursing state administration of nebulizer treatment. Competency by Licensed Nursing state administration of nebulizer treatment. Competency by Licensed Nursing will be completed. Each nurse signing for completion of the nate they not only verify that they pethe nebulizer treatment procedure that their signature verifies that they remained with resident during the course of the treatment as a necessary part procedure. 4. The DNS or designee will two audits per week for four woweekly for two months to ensure compliance. 5. The data collected will be reviewed/discussed at quarter	alleged or tement of tection sexecuted atte and waiving the y states red to coulizer een g staff are eir breathing ed by 2-3-ff on atments that dent during A clinical sing Staff event of the ealso on the ne nebulizer of the complete eeks then re		

Facility ID: 00731

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245378	B. WING		12/:	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	room. R6 was sitting no longer had the machine running. When interviewed of director of nursing (have an assessment medications; the machine to remain with the rate treatment. The DOI history of being nor of nebulizer treatment. The facility policy/princluded: "10. More the treatment." 483.15(f)(1) ACTIV INTERESTS/NEED The facility must proof activities designed the comprehensive	N)-D was observed in R6's ag on the edge of bed though ebulizer mask on nor was the on 12/31/15, at 9:09 a.m. the DON) confirmed R6 did not at to self administer redication nurse was expected esident throughout a nebulizer of further confirmed C6 had a altrompliant with administration ents.	F 176	meeting. At this time the QA&A committee will make the decision/recommendation regardin follow-up studies. The DNS is responsible for the PO Completion Date: 2-8-16	C.	2/8/16
	by: Based on observat review the facility fa of 3 (R6, R23) resid Findings include: R6 R6 was admitted to	NT is not met as evidenced ion, interview, and document illed to provide activities for 2 dents reviewed for activities. the facility on 9/5/14, with a dementia without behavioral		The preparation of the following pl correction for this deficiency does reconstitute and should not be interpas an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was exsolely because provisions of states.	not reted t by the ed or ent of n ecuted	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION	` '	E SURVEY PLETED
		245378	B. WING _	· · · · · · · · · · · · · · · · · · ·	12/;	31/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	-	.,
VALLEY	VIEW MANOR HCC			200 EAST NINTH AVENUE		
VALLEI	VIEW MANOR 1100			LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 248	Continued From pa	ge 17	F 24	18		
F 248	disturbance, cognitic chronic obstructive muscle weakness a facility diagnosis reports of the portion of the assessment dated impaired cognition of the assessment daily. The neither the resident could complete the portion of the asses of daily and activity resident preferred resident preferrences of Charlie Chan movie R6's care plan for a indicated the resident preferred resident preferrences of Charlie Chan movie R6's care plan for a indicated the resident preferrences of Charlie Chan movie preferrences of Charlie	ive communication deficit, pulmonary disease (COPD), and difficulty walking per the port. Import. Im	F 24	federal law require it. Withou foregoing statement, the facil with respect to: 1. Resident s #6 and reside recreation/wellness assessmed been reviewed and their care activities have been updated includes more specific activities appropriate for them. 2. All residents will be reviewed activity department to ensure appropriate activities are in ploof them. 3. Education on resident appropriate activities will be completed by all staff meeting. The activity will create a daily activity log to that appropriate activities are each resident. Where difficulties each resident. Where difficulties each resident. Where difficulties each resident who are more challenging, the IDT will be entirely develop a plan for appropriate activities. 4. The Activity Director or decomplete 2 audits weekly for weekly for 2 months to ensure resident s are receiving activities. 5. The data collected will be reviewed/discussed at the quince meeting. At this time the QAR committee will make the decision/recommendation region. The Activity Director and MDS.	ent #23 sent have plans for which es that are wed by the that ace for each propriate 2-5-16 at an department o ensure in place for ties may civities for ore plisted to priate esignee will 4 weeks and e that the vities established and each action of the same of the same established and each action of the same of the same established and each action of the same of the same established and each action of the same established action of t	
	structuring leisure a			The Activity Director and MDS Coordinator will be responsib POC.		

AND DUAN OF CODDECTION INDED.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245378	B. WING		12/	31/2015
	NAME OF PROVIDER OR SUPPLIER VALLEY VIEW MANOR HCC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 (enjowrestling and war movies) food related activities ensory 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 an individual cardio. The activity goal indicated Fix would work on puzzles in day room by the reviperiod. When interviewed on 12/29/15, at approximate 8:50 a.m. the director of nursing (DON) confire R6 did not speak or understand English. DON further indicated staff communicated with the resident through gestures and facial expression.			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	,	01/2010
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 248	(1.) CD player in roresident's desire. (2.) Recreation/We exercise, listening twrestling and war resensory and 1:1 tin (3.) EMOTIONAL: (individual music en (4.) PHYSICAL: En Well-Fit program to individual cardio. Twould work on puzzeriod. When interviewed (8:50 a.m. the direct R6 did not speak of further indicated staresident through get Continuous observ 1:16 p.m. until 4:17 - At 1:16 p.m. R6 wassistance of two sresidents wheelchawest Cityside hallwenglish to his voca the length of the haw/c, removed the trhim to the dayroom station. Staff move	om; please play music per Illness preferences include: to music, watching TV (enjoys novies) food related activities, ne. Offer ipod or CD player for joyment. courage participation in include group exercise and/or he activity goal indicated R6 zles in day room by the review on 12/29/15, at approximately tor of nursing (DON) confirmed runderstand English. DON aff communicated with the estures and facial expressions. Actions of R6 on 12/29/15, from r. p.m., revealed the following: As ambulated with the staff, a 3rd staff pushed the lizations. After R6 ambulated all staff seated him back in the cansfer belt and transferred a area located by the nurses' and him self in the w/c lied himself in the w/c	F 248	Completion date 2-8-16		
	R6 a round shaped of multiple-colored	ing assistant (NA)-A brought I sensory item which consisted hollow tubes held together ford. This enabled the object to				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245378	B. WING		12	/31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP C 200 EAST NINTH AVENUE LAMBERTON, MN 56152		,01,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 248	be stretched and mitem, talking out lou held the item, he dinhe attempt to manip NA-A left the area at R6. R6 remained in p.m., when licensed assisted him back to the assisted him back to the assisted him back to the assisted him with the left the area. With a continued to vocalized down the west hallwarrived at the end of and returned him back to the assisted him with the left the area. With a continued to vocalized down the west hallwarrived at the end of and returned him back to the assisted him with the activity room, to attend to him earlier was not touching not though he appeared time, a popcorn and in the activity room, to attend. At 2:14 particular, a popcorn and in the activity room, to attend. At 2:14 particular, a popcorn and in the activity room, to attend. At 2:14 particular, as popcorn and in the activity room, to attend. At 2:14 particular, as popcorn and in the activity room, to attend. At 2:14 particular, as popcorn and in the activity room, to attend. At 2:14 particular, R6 was a music was playing in 4:17 p.m., R6 was a remove and replaced Although coffee soon	anipulated. R6 accepted the ad constantly. Although R6 d not appear interested nor did bulate or pull the sensory item. after the item was delivered to a the commons area until 1:44 d practical nurse (LPN)-C to his room. It his room via the w/c to blastic mug from the drinking the west hallway. Staff he task, replaced the lid and a water-filled mug, R6 to as he propelled the w/c way. It was noted that once R6 f the hallway, staff intercepted	F 2	48		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	` '	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZII 200 EAST NINTH AVENUE LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 248	this time, R6 was nattend. At 3:10 p.m greeted R6. Traine also entered the rostill "working on his whether R6 was su TMA-A responded and on R6, they cound and not worry about assist R6. Observations of R6 following: - At 7:50 a.m. R6 witable in the corner of breakfast independ flush to the wall on the other resident's the wall. At 7:58 a. by staff to the Citystable. Staff handed shaped sensory ob when manipulated, without further interbehind him on the sto propel self past the dining room to the in was standing. R6 without further interbehind him on the sto propel self past the dining room to the in was standing. R6 without further interbehind him on the sto propel self past the dining room to the in was standing. R6 without further interbehind him on the sto propel self past the dining room to the in was standing. R6 without further interbehind him on the stop propelling the propelling the propelling was lying on his been exposed and beddibed; no pillowcase observed holding of sit up in bed.	ot assisted or offered to n. NA-C entered the room and of medication aide (TMA)-A om and asked whether R6 was shoe". NA-C asked TMA-A pposed to have the shoe. that if NA-C could get it laced uld transfer him into his chair t it, however NA-C did not on 12/30/15 revealed the as observed seated alone at a of the dining room eating ently. The table was pushed 2 sides. R6 had his back to in the dining room, facing only m. R6 was assisted in the w/c ide dayroom and placed at a if R6 a multicolored cylinder ject that also made sound Staff then left the area action. R6 placed the object seat of his w/c and proceeded he nurses' station towards the medication cart where LPN-C rocalized loudly. LPN-C at he had already eaten and high him back to his room. Hent's room at 8:05 a.m. R6 d with the bare mattress ng in a clump at the end of was on R6's pillow. R6 was into the grab bar, attempting to	F 2	48		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245378	B. WING		12/	31/2015	
	PLAN OF CORRECTION 245378 ME OF PROVIDER OR SUPPLIER LLEY VIEW MANOR HCC (4) ID REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		:	STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE	
F 248	himself down the waturned the corned, and propelled him is hallway. R6 then erself around the perlook out the window in the fish tank. R6 direction of the east near this area until R6 from the east hadayroom. No verbainteraction was not offered/assanytime throughout did staff interact with was not offered as an param. R6 was seated near nurses station entered the dayroo the volume on the where the men's gramain area of the did were noted to interact out of the dining room at 2:44 p.m. When interviewed of AD stated R6 is very and is scheduled for stated staff will also staff	the administrator redirected the administrator redirected back down the direction of the othered the dayroom, propelling imeter of the area, pausing to and then watched the activity propelled himself toward the thallway and remained seated 10:30 a.m. LPN-C then moved allway to a table located in the allocated in the allocated to the church activity at the noted observations nor the the resident. It was observed seated in w/c in station; Wellness activity was and was identified on the planned intervention. At 11:27 and in w/c in Cityside dayroom when the activity director (AD) m, said "Hi" to R6, turned up	F 248				

PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 248 Continued From page 22 1:1 visits weekly. AD confirmed there was a language barrier related to attending activities	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW MANOR HCC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 248 Continued From page 22 1:1 visits weekly. AD confirmed there was a language barrier related to attending activities STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 248 F 248			245378	B. WING		····	12/	31/2015
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 248 Continued From page 22 1:1 visits weekly. AD confirmed there was a language barrier related to attending activities					200 I	EAST NINTH AVENUE		
1:1 visits weekly. AD confirmed there was a language barrier related to attending activities	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE	(X5) COMPLETION DATE
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 lpod with headphones for R6 to listen to music in his own language. The AD then provided documentation indicating the lpod 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	F 248	1:1 visits weekly. A language barrier re and that an interpret to the facility on 12 since. AD stated trinterpreter but calls stated a few weeks another facility campossible placement to converse with Rediscovered he enjour When requested deactivities provided to noted: (11/2/15 thr two 1:1's with staff 11/16-11/22/15 R6 the AD indicated shocumentation to complemented nor concurred. AD states headphones for Relanguage. The AD indicating the lood November and 4 to When questioned a (wrestling and war care plan, she indicated that attending highlighted and/or chad been involved observations.	AD confirmed there was a elated to attending activities eter from the high school came /4/15 but had not returned rying to get hold of the had not been returned. AD ago a representative from the to assess the resident for the representative was able in his native language and ryed weaving baskets. Cocumentation related to for R6, the following was to 12/12/15) -R6 received only (11/4 & 11/7). The week of received 1:1 activity. Although the had provided 1:1 in-room R6, she was unable to provide demonstrate this had been could she recall when this had to she offered an Ipod with the to listen to music in his own then provided documentation was offered 5 times in times in December 2015. The about the preferred activities movies) documented on R6's cated being unaware of these on the current activity sheets ubstantiate the activities each ded, there was nothing documented indicating that R6 in activities during the days of the viewed on 12/31/15, at 10:21		248			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152		70172010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 248	of activity sheets for days of documental indicated R6 attend the AD stated he disactivity sheets failed participated, wands activity; the AD condocumentation was R23 R23 was admitted including: demential disorder, and chrond disease (COPD) per The report further in the hospice services on degeneration of the R23's quarterly Min assessment dated severely impaired on with locomotion on assistance with bed to illet use, and pers R23's significant chrospicate in religion R23's care plan las resident was deper and providing activity stimulation due to cincluded: (1) "1 to	or 10/15, and provided only tention for 12/15. The sheets ded exercise on 12/21/15, and d really well with it. The d to document whether R6 had ered away and/or refused the afirmed the activity incomplete. on 1/6/15 with diagnoses a, paranoid personality, mood nic obstructive pulmonary er the facility diagnosis report. dentified R23 was admitted to a 5/15/15 due to senile e brain.	F 24	.8		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY MPLETED		
		245378	B. WING		12	/31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZII 200 EAST NINTH AVENUE LAMBERTON, MN 56152	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 248	of room events. (2) participation in smainteractions (3) EM player for individual ENVIRONMENTAL body language relating [Resident name] Repreferences included word search, TV and R23 was observed from 1:14 p.m. until A popcorn and moven, in the activity ractivity held at 2:30 did not offer R23 thactivity. R23 was again obs 12/30/15, from 10:010:03 a.m. R23 was Cityside dayroom a service was current room. At 10:21 a.m. R23 reyes closed. The Aresident seated in volumes station and attend church. R2 AD and the resident away and closed hearea. NA-A then apto ask whether she nodded "yes". NA-opportunity to attent transporting her to live the state of	COGNITIVE: Encourage all groups and/or 1:1 lOTIONAL: Offer ipod or CD music enjoyment. (4): Observe [resident name] and the to over stimulation ecreation/Wellness individual and listening and playing music." continuously on 12/29/15, 3:56 p.m. while lying in bed. are activity was held at 1:30 and and the coffee social p.m. in the dining room. Staff e opportunity to attend either a table while a church at a table while a church at a table while a church are with a paproached another with a paproached R23 at 10:23 a.m. wanted to lay down. R23 and did not give her the did not give her the did the church activity before	F 2	48		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245378	B. WING _		12	/31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CO 200 EAST NINTH AVENUE LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 248	eyes closed while a process. She had to attend this activities. At 3:12 p.m. R23 we closed. A music at the Cityside dayroomember piano play to offer attendance. When interviewed NA-B and NA-A cowith her morning cativities, she ofter down. Both NA's of R23 attendance at R23 had been tear receiving care and rather lie down. NA liked to color when church though at tiduring the service. When interviewed AD stated R23's addily Sunshine growing lemented twice on Saturdays). AD does fine while attest sometimes needed service as would gwould still expect F to participate in atte to located document and 1:1's provided sheets indicated R2 times/weekly. AD from 11/2/15 - 12/5	a Wellness activity was in not been given the opportunity	F 24	18		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY PLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 248	7 occasions during 11/12/15, 11/13/15, AD confirmed the 1 and did not identify response. Staff wore effectiveness of pla. When interviewed of AD provided 10 day sheets for R23. The offered activities on unable to provide doffered in November activity sheets for C sheets did not inclused the control of th	this period (11/5/15, 11/7/15, 11/27/15, 12/4/15, 12/7/15). :1 charting was inadequate the activity, time and/or ald not be able to evaluate	F 24	48		
F 282	483.20(k)(3)(ii) SEF	RVICES BY QUALIFIED	F 28	32		2/8/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '			ATE SURVEY DMPLETED	
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	PROVIDER OR SUPPLIER VIEW MANOR HCC		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	. =, .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE ((X5) COMPLETION DATE	
F 282 SS=D	PERSONS/PER CATTRIBUTE THE SERVICES provided by accordance with eacare.	_	F 282				
	by: Based on observatoreview the facility farelated to activities reviewed for activities reviewed for activities. Findings include: R6 When interviewed of 8:50 a.m. the direct R6 did not speak of further indicated staresident through get R6 was admitted to diagnoses including disturbance, cognit chronic obstructive muscle weakness a facility diagnosis retaility diagnosis retailed but occasionally nestructuring leisure a wellness. Intervent plan:	tion, interview and document ailed to follow the plan of care for 2 of 3 (R6, R23) residents es. on 12/29/15, at approximately for of nursing (DON) confirmed a understand English. DON aff communicated with the estures and facial expressions. The facility on 9/5/14, with g dementia without behavioral ive communication deficit, pulmonary disease (COPD), and difficulty walking per the		The preparation of the following placorrection for this deficiency does not constitute and should not be interprated as an admission nor an agreement facility of the truth of the facts allego conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was exesolely because provisions of state a federal law require it. Without waiv foregoing statement, the facility state with respect to: 1. Resident #6 and Resident #23 care related to activities was review updated to meet their individualized needs. 2. All residents are assessed for the activity preferences upon admission quarterly and with a significant charactivity preferences upon admission quarterly and care plans are updated ensure appropriate interventions are implemented. All Residents have he care plans reviewed to ensure that of them are receiving appropriate activities. A special care plan meet hosted by the Activities Director will conducted quarterly to ensure that activities are being instituted and	not reted by the ed or ent of n ecuted and ing the tes plan of red and I heir n, nge in ed to e ad their each ing		

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245378	B. WING			12/3	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE .AMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	2. Recreation/Well exercise, listening the wrestling and war in sensory and 1:1 tim 3. EMOTIONAL: Condividual music en 4. PHYSICAL: End Well-Fit program to individual cardio. The would work on puzz period. On 12/29/15, R6 with 1:16 p.m. until 4:17 - At 1:16 p.m. R6 with assistance of two sersidents wheelchawest Cityside hallwhold length of the hall stremoved the transfithe dayroom area lost Staff moved him in R6 propelled himsed dayroom. -At 1:27 a.m. nursinar ound shaped semultiple-colored hobungy type cord. The stretched and manifem, talking out lounded the item, he did he attempt to manifem, NA-A left the area at R6. -At 1:34 p.m. a staff.	Iness preferences include: to music, watching TV (enjoys novies) food related activities, ne. Offer ipod or CD player for joyment. courage participation in o include group exercise and/or he activity goal indicated R6 zles in day room by the review as observed continuously from	F 2	282	planning; this special meeting will be documented and will involve member the IDT. This meeting will be in ad to care plan updates on admission quarterly, and on change in condition 3. Education will be completed by for all staff on following intervention planned for all residents. 4. The DNS or designee will complete two audits per week for 4 weeks are weekly for two months to ensure compliance in these areas. 5. The data collected will be reviewed/discussed at the quarterly meeting. At this time the QA&A committee will make the decision/recommendation regarding follow-up studies. The DNS and Activity Director will be responsible for this POC. Completion Date: 2-8-16	ers of dition on. 2-5-16 as care olete ad then v QA&A	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245378	B. WING			12/:	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	sensory object reminteraction between remained at the tab began to propel the -At 2:00 p.m., R6 w top of covers with s given to him earlier was not touching not though he appeared time, a popcorn an in the activity room. -At 2:07 p.m. it was on edge of bed with sensory item remai again noted that R6 interested in this series and in the activity room. Sensory object was music was playing it -At 2:39 p.m., R6 reference the bed attempting shoe. R6 had a newere present in the Coffee social and wheld in the dining room of the laces from the laces from the remove	ued to verbalize while the ained on his lap. No a staff and R6 occurred. R6 ble a short time and then aw/c around the dayroom. The sensory item was placed on his legs. R6 or handling the item even do to be wide awake. At this do movie activity was occurring the noted that R6 was sitting up a feet dangling down; the ned on resident's lap. It was as was not touching nor ensory object. The as seated on the edge of his the left shoe off and was holding the laces. The no longer visualized. No in the room. The mained seated at the edge of to pull the laces from his left bulizer mask on and no staff room during this observation. For yord games activities were	F 2	282			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245378	B. WING _		12	/31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	1 2	01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 282	entered the room a medication aide (TI and asked whether shoe". NA-C aske supposed to have that if NA-C could could transfer him i about it. On 12/29/seated on the side without laces. R6 a shoe. The Wellnes schedule for 4:00 p seated on edge of land was attempting the shoe. This active 2:30 p.m. (almost 22:30 p.m. (almost 22:30 p.m.) (almost 22	MA)-A also entered the room R6 was still "working on his d TMA-A whether R6 was he shoe. TMA-A responded get it laced and on R6, they nto his chair and not worry 15, at 3:57 p.m. R6 remained of bed, holding his left shoe ppeared to be examining the as group was on the activity .m. At 4:17 p.m. R6 remained bed, holding onto the left shoe of the replace the laces back in with had been continuous since	F 28	32		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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F 282	noted between staf offered/assisted to throughout the note interact with the result of the control of the contr	f and R6. R6 was not the church activity at anytime od observations nor did staff	F 2	82		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		TE SURVEY MPLETED				
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F 282	When questioned a (wrestling and war care plan, she indic preferences. When were reviewed to si resident had attend highlighted and/or chad been involved observations. When further interval.m. the AD provide activity sheets which activities on 8 of the activity sheet dated resident was offere stated she sat next he did really well. It provide documenta November 2015 and sheets for October plan of care was not sheets for October plan of care was not micluding: demential disorder, and chronidisease (COPD) per The report further in hospice services or degeneration of the R23's care plan las resident was dependent and providing activistimulation due to coincluded: (1) "1 to activities if [resident was detailed to coincluded: (1) "1 to activities if [resident was detailed to coincluded: (1) "1 to activities if [resident was detailed to coincluded: (1) "1 to activities if [resident was detailed to coincluded: (1) "1 to activities if [resident was detailed to coincluded: (1) "1 to activities if [resident was detailed to coincluded: (1) "1 to activities if [resident was detailed to coincluded: (1) "1 to activities if [resident was detailed to coincluded: (1) "1 to activities if [resident was detailed to coincluded: (1) "1 to activities if [resident was detailed to coincluded: (1) "1 to activities if [resident was detailed to coincluded: (1) "1 to activities if [resident was detailed to coincluded: (1) "1 to activities if [resident was detailed to coincluded: (1) "1 to activities if [resident was detailed to coincluded to coincluded to coincluded to coincluded to coinclude	about the preferred activities movies) documented on R6's cated being unaware of these in the current activity sheets obstantiate the activities each ded, there was nothing documented indicating that R6 in activities during the days of viewed on 12/31/15, at 10:21 and 10 days of December 2015 and indicated R6 was offered at 10 days. AD stated the 112/21/15, indicated the defined the exercise activity. AD to R6 during the activity and However, the AD was unable to attion of activities offered in and provided 5 days of activity 2015. It was confirmed the out implemented as written.	F 2	82		

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F 282	participation in smale interactions (3) EM player for individual ENVIRONMENTAL body language rela [Resident name] Repreferences include word search, TV ar R23 was observed from 1:14 p.m. until A popcorn and mov p.m. in the activity ractivity held at 2:30 did not offer R23 th activity. R23 was again obs 12/30/15, from 10:010:03 a.m. R23 was Cityside dayroom a	ge 33 all groups and/or 1:1 IOTIONAL: Offer ipod or CD music enjoyment. (4) : Observe [resident name] ted to over stimulation ecreation/Wellness individual e Bingo, walks, magazines, and listening and playing music." continuously on 12/29/15, 13:56 p.m. while lying in bed. re activity was held at 1:30 room and the coffee social p.m. in the dining room. Staff e opportunity to attend either erved continuously on 3 a.m. until 10:23 a.m. At as seated in a geri chair in the t a table while a church tly being held in the activity	F 2	282		
	eyes closed. The Aresident seated in working nurses station and attend church. R2 AD and the resident away and closed hearea. NA-A then are to ask whether she nodded "yes". NA-opportunity to attent transporting her to At 11:08 a.m. R23 was not seat to a se	remained in the geri-chair with ND approached another w/c located near the Cityside asked whether she wanted to 3 opened her eyes when the t left for church but looked er eyes when they left the oproached R23 at 10:23 a.m. wanted to lay down; R23 A did not give her the d the church activity before her room.				

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F 282	process. She had it to attend this activition attend this activition attend this activition attend the cityside dayroo member piano play to offer attendance. When interviewed on NA-B and NA-A conwith her morning care activities, she often down. Both NA's on R23 attendance at R23 had been tearforeceiving care and rather lie down. When interviewed on Saturdays). AD expect R23 be offer participate in attendicated documentation 1:1's provided for Rindicated R23 was times/weekly. AD provided 10 days to the constant of the c	as again lying in bed with eyes tivity was being performed in m with a resident's family ing. Staff were not observed to the activity to R23. In 12/30/15, at 11:55 a.m. of firmed they had assisted R23 ares, stating that when offered refuses as prefers to lie confirmed they had not offered the morning church activity as all that morning when they felt the resident would on 12/30/15, at 1:40 p.m. the tivities included hair care, a up (sensory group) which is daily Monday-Friday and once confirmed she would still red the opportunity to ling church. AD attempted to tion of activities attended and 23. The 1:1 activity sheets	F 2	282			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 309 SS=G	offered in November activity sheets for Consets did not inclused and participated or confirmed the chart incomplete. The plaimplemented as writed 483.25 PROVIDE CONTROLL BUTTONION TO THE CONTROLL BUTT	ocumentation of activities or 2015 and provided 5 days of October 2015. The activity de evidence if the resident refused the activity; AD ing of activities was an of care was not litten. CARE/SERVICES FOR	F 2			2/8/16
	by: Based on interview facility failed to provand services for 2 or reviewed who had be resulted in actual haprolonged discomforelated to delayed ritransfer to an inpatiobstruction. In add provide appropriate			The preparation of the following correction for this deficiency does constitute and should not be inter as an admission nor an agreeme facility of the truth of the facts alle conclusions set forth in the stater deficiencies. The plan of correcti prepared for this deficiency was a solely because provisions of state federal law require it. Without was foregoing statement, the facility swith respect to: 1. Resident #46 is deceased. facility found a more appropriate placement for resident #6. This for has Hmong speaking staff. This	s not preted nt by the eged or nent of on executed e and diving the tates The acility	

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F 309	R46's discharge or dated 9/17/15, iden improving with order occupational therapy R46's physician's prindicated diagnose lumbar region, septime physician's prohistory of diverticuli R46's admission M 9/24/15 identified a Status score of 13/2 area assessments R46's care plan, date of the status of	ders to the nursing home utified a discharge condition of ers for physical and by. Irrogress notes, dated 9/18/15 is of spinal stenosis of the sis, and urinary tract infection. It is of the colon. Inimum Data Set (MDS), dated in Brief Interview for Mental 15 (cognitively intact). No care were completed with the MDS. Intel 9/30/15 identified no ints and that R46 desired to	F 30	will be closer to his family and be in a dementia unit that is a quieter as recommended by his primary physician. 2. All residents have been reviewensure that any non-English speal someone in the facility who speak language. All residents have beer reviewed for any significant chang condition and need to notify the phand DNS. 3. Education to licensed staff will completed by 2-3-16 on significan change in resident condition, physical notification with any change in resident condition and the importance of his someone available to speak the la of all non-English speaking resided. Nurses will notify the physicial	ved to ker has s their ne in hysician I be tician Sident aving unguage nts.	
	revealed R46 had r 30 cubic centimeter four times on that of 2:00 a.m. on 9/26/1 licensed practical in the medication adn administered on 9/3 the medication had since supper. No f effectiveness was dentry dated 9/26/15 had received anoth stomach and emes listed as had anoth the other doses ad results documented	2015 medication sheets received Maalox (an antacid) rs (cc)'s on 9/25/15 a total of late, as well as one dose at 15. Notations documented by larse (LPN)-A, on the back of ninistration record for a dose 25/15, at 2:00 a.m. indicated 1 been given for stomach upset ollow up assessment for completed. A subsequent 5, at 2:00 am. indicated R46 are dose of Maalox for an upset sis; the follow up result was er emesis at 4 a.m. None of ministered had follow up d.		immediately (in a timely manner) or residents have a significant chang condition and they will also notify the Director of Nursing. They will not use fax to communicate these ser issues regarding residents. Prior admission the facility will ensure the issomeone available who speaks language of any non-English speats. The DNS or designee will contaudits weekly for 4 weeks and we 2 months to ensure that the facilities guideline is being followed correct 6. The data collected will be reviewed/discussed at the quarter meeting. At this time the QA&A committee will make the decision/recommendation regarding follow-up studies.	when e in he onger ious to nat there the ker. nplete 2 ekly for es ly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 309	and complaints of rindicated R46 had be along with Thorazing after his morning me had experienced a the bed and himself anything for breakfa orange juice that had a nursing progress on 9/25/15, at 1:39 large emesis, and the was not feeling well hiccups had subsidicted again. Docureceived Maalox and medication used for another small emest documented as have and was described R46's temperature been elevated at 950 A nursing progress p.m. per LPN-F ind most of the evening hiccups were better but that R46 had be feel right and that we to gag. R46 had easips of water. Additindicated a fax (fact medical doctor (MD condition including temperature at 99.5 feeling chilly.	indicated R46 had hiccups not feeling well. The notes been given Maalox 30 cc's e and had begun retching edications. In addition, R46 large projectile emesis all over f, and had refused to eat ast, stating he had consumed	F 3	The DNS is responsible Completion Date: 2-8-			

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F 309	feeling well, and had emesis twice on the appear to have a febeen given to help vitamins had been of the appear to have a febeen given to help vitamins had been of the appear to have a febeen given to help vitamins had been of the appear to had been of the appear to had been had be	icated R46 had not been d been having brown colored afternoon shift which did not bees odor. Maalox 30 cc's had with hiccups and R46's held due to emesis. Inote by LPN-A, dated 9/26/15, ed R46's abdomen was el sounds were difficult to hear aving emesis which looked like as noted to be slightly elevated note written by LPN-A on in. indicated R46 had 100 cc's formed/loose BM (bowel odor. The note further cool and clammy, with a inperature at 99.1 degrees F. isket beside him, and	F 30			

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F 309	An additional nursing 9/26/15, at 2:06 p.n admitted to the acu diagnoses of bowel surgery. A faxed physician's p.m. from the facilitidentified that R46 is experienced several throughout the day drink. R46 complained had not been signed days later, when the responded with a sitelephone order to the Please do NOT fax need attn [attention [physician] - today of faxing for response. The ER progress note in a.m. was reviewed. The ER progress note in the progress of a.m. was reviewed. The ER note further was firm and diffuse with dried brown matched the physician's note incomplysician's note	org progress note dated n. indicated R46 had been te care hospital with a obstruction, and would need order sent on 9/25/15, at 6:05 y to R46's primary physician had emesis since 8:30 a.m.,	F3	309			

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F 309	he'd been vomiting emesis was now brownited three times the ER and the von brown liquid running abdomen was very and the abdomen was very and the abdomen was very and the abdomen was omplained of abdomate the pain. R46 nasogastric tube for fluid output after who better. R46 was allowed what ever we have The hospital discharing indicated R46 had to correct the small developed subsequanticoagulation is surgery. The ileus of a nasogastric tube were initiated and Fouring interview on director of nursing expected staff to commediately with the specially when the BM-type material and During interview on nursing home's head coordinator/nursing LPN-B was not well hospital intensive of	m. indicated: R46 had stated for the last two days and his own like stool. R46 had in the ambulance enroute to nit was described as darking out of his mouth. R46's firm, with no bowel sounds was distended. R46 ominal pain but was unable to had his stomach drained via a reten minutes with 1400 mL of nich R46 stated he felt much ert and "states we should do to do. Is comfortable now." arge summary dated 10/5/15, undergone abdominal surgery bowel obstruction, and had use as well as post-operative normal bowel motility) after the resolved with the replacement pe; however, comfort cares R46 passed away on 10/5/15. 12/29/15, at 3:07 p.m. the (DON) verified she would have ontact the on-call doctor e urgent clinical issues, a resident was vomiting and not feeling better.	F 30			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 309	acting administrator the time of the incic R46's family had in hospital with a bow later been found to administrator was a regarding R46's epstated she would he contact/call the ondirectly with concer administrator states staff to check the vistatus, appetite and a physical assessmishe thought LPN-A her judgment. She every Thursday nig When LPN-A was in on 12/29/15 at 4:02 received report from on 9/25/15, regardi been unaware a fastated she'd worker prior and was awar complaints of not for She was aware R4 been eating well, and administered Maalox first time she admin LPN-A verified R46 like stool but there abdomen had also LPN-A was unawar complained of pain	in 12/29/15, at 3:45 p.m. the r, who had been the DON at dent stated she'd thought dicated he was admitted to the el obstruction, but that it had be a narrowed bowel. The unable to recall specifics isode of illness; however, ave expected staff to call and/or primary physician ms that were urgent. The dishe would have expected the ital signs, bowel movement diffever status while conducting nent. The administrator stated was a good nurse and trusted further verified LPN-A worked hit shift. Interviewed about the incident of p.m., LPN-A stated she'd in the evening nurse (LPN-F) in R46's emesis, but had in the evening nurse (LPN-F) in R46's vomiting and deling well was new for R46. In the had subsequently but during the night. LPN-A in had helped somewhat the instered it (around 2:00 a.m.). In had emesis of what looked was no odor. She verified his seemed a little distended. The whether R46 had	F 309				

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	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP 200 EAST NINTH AVENUE LAMBERTON, MN 56152			
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F 309	later in her shift (and she'd become conditions something wrong wished she'd proceed paperwork for a hornot call the RN on the concern. LPN-along the paperwork nurse, LPN-B, who on 9/26/25. LPN-A an assessment to fouring the interview there had been a hishe had noted whe pass along to the doministra notified the physicial symptoms, and that there had been a diphysician notification. During interview on medical director was would have expected they filled out the pass along to the pass along to the diphysician notification. The nalthough R46 may anyway, prompt medical director was would have expected they filled out the pass along to the pass along to the pass along to the pass along to the diphysician notification. The nalthough R46 may anyway, prompt medical doctor delayed more related to R46's medical doctor (ME) and the pass along	cound 5:00 a.m.) at which time beened that he may have with his small bowel. LPN-A ed to fill out all the transfer spital discharge; however, did call nor notify the physician of A indicated she had passed k and her concern to the day arrived on duty at 6:00 a.m. stated she'd told LPN-B to do ollow up on R46's condition. v, LPN-A stated she thought istory of small bowel concerns in filling out the paperwork to ay shift personnel. Interview on 12/30/15, at 9:12 tor stated LPN-A should have an sooner about R46's t she had not been aware elay in his nursing care and	F3	809			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245378	B. WING		12	/31/2015	
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' ((EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 309	stated faxing medic p.m. was inappropring not attended at that he'd been concerns ischemic bowel who due to the delay in after his symptoms made some "deprehospital transfer on were a "sidebar" ar issue. MD-A confirmore comfortable is sooner in the ER. I vomiting brown sturyou are seen." The facility's policy SBAR last revised notification of the psymptom, sign or a sudden in onset, a severe) in relation that and was unrelieved prescribed. The posection related to a immediate notificat required when thereof marked tenderned (gastrointestinal) bl Review of R21's MRecord (MAR) date that blood sugar (B five (5) times per deciliter (dL) and all documented BS levents in the second mediciliter (dL) a	g stool-like material. MD-A cal staff at the clinic at 6:00 iate as the fax machine was a time of day. MD-A stated ed about the potential for en R46 arrived at the hospital, receipt of medical attention began. MD-A stated R46 had ssed" comments prior to the 9/26/15, but those comments and were not relevant to this med R46 would have been f he had been examined MD-A stated, "when you are ff, it is probably a good idea if entitled Change in Condition 3/15, indicated immediate hysician was required for any pparent discomfort that was marked change (i.e. more o usual signs and symptoms by measures already solicy further indicated in a bdominal distension that ion of the physician was e was rapid onset, or presence ess, fever, vomiting or GI	F3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245378	B. WING			12/:	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE .AMBERTON, MN 56152		
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F 309	physician notification registered greater to a physician's order, Insulin Regular Hurris." A physician's order, Insulin Glargine So subcutaneous (SQ) sliding scale with Runit/ml. BS reading diabetic educator will listed for notification hypo (Iow) or hyper During interview on licensed practical in were no protocols, notify the medical of LPN-C stated she whow the resident fe BS-which she ident 500's". On 12/30/15, at 2:3 would notify the ME above 600 mg/dL. 12/29/15, the suppomg/dL and the MD further stated R21 flabove 400 mg/dL aread to give 6 units was greater than 35 when the glucomet	ally, there had not been on of blood sugars which	F	809			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		245378	B. WING		12	/31/2015	
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	_	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 309	the nurse on call at reading. During interview on diabetic educator in reports of R21's BS the clinic has a protadjustments and the were based upon. Stated R21 had a hand nursing staff we medical provider or related to changes educator further incomparameters had be recently discharged 12/5/15. She indicated have been determined buring interview on and RN-C stated the for reporting BS read documentation on the standard RN-C indicated that would followed unless indicated written. RN-B indicated on the standard RN-C indicated Change in Condition reporting of BS read RN-B stated, "we we everyone is aware on the standard RN-B stated, "we were a months at the factor BS checks whice the condition of the standard RN-B stated, "we were standard she had the stand	the hospital to report the 12/30/15, at 2:57 p.m. the adicated she received weekly results. She further stated tocol for diabetic medication is was what insulin changes. The diabetic educator further istory of being a brittle diabetic ere supposed to call the a call and/or the triage nurse in status. The diabetic dicated she thought BS en identified when R21 was a from the the hospital on ated the parameters would need by the discharging MD. 12/30/15, at 3:12 p.m. RN-B are were facility parameters adings. They referenced the he facility's standing orders all be the practice they ividualized orders were sated if a resident was rould notify the physician ing order instructions. RN -B of they were not aware of the nolicy related to immediate dings above 430 mg/DL. will have to make certain	F3				

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 309	specific insulin order "high" reading she for direction. In the R21 LPN-E indicate ordered SS dose at then recheck in the whether the BS was tated she would put instance as this fluctuations. LPN-E have specific orders she would do. On 12/31/15, at 9:0 the facility's medicaresident would have from the hospital for physician stated R2 before admission to history of blood sugthat the resident was when her blood sughowever, stated if so for an elevated blood provide specific order required to recheck results. She stated 'hi' because they have blood sugar is beloto initiate the hypogindicated she would and/or on-call staff were outside range.	s for a sliding scale (SS), or a ser. LPN-E stated if there was a would contact the MD on call instance of a 400+ reading for sed she would administer the nd recheck in one hour and following hour to determine as responding to insulin. LPN-E robably not notify the MD in a resident has a history of BS further indicated R21 did not as for follow up but this is what as a specific order that comes or sliding scale insulin. R21's 21 had been her patient even to the nursing home, and had a gars fluctuating "all over" but as usually most comfortable gars ran over 300 mg/dl. She'd received a telephone call be sugar level she could ders as to when staff were at the BS and call back the they call if the meter reads ave nothing to base it off. If the w 70 mg/dL staff would need glycemia protocol." She further dexpect staff to notify the clinic to update on BS readings that	F 30	9			
	2015 documentation	n of R21's BS readings and unaware of the wide fluctuation					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				E SURVEY IPLETED	
		245378	B. WING			12/	31/2015
_	PROVIDER OR SUPPLIER VIEW MANOR HCC			200	EET ADDRESS, CITY, STATE, ZIP CODE EAST NINTH AVENUE MBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	of BS readings for I mg/dL. She confirr staff to notify the at staff in accordance When to Report to The facility's policy notification for blood Change in Condition MD/nurse practition last revised 3/15, in than 430 mg/dL (or diabetic patients us be immediately reppractitioner (NP)." When interviewed 8:50 a.m. the DON understand or be uncommunicated using expressions. The facility diagnos admitted to the faciling dementia with a cognitive corresponding demential with a cognition with daily intruded on the privible behavior towards or not directed toward than daily. The MD extensive assistant locomotion on/off unpersonal hygiene. The interview of the privible intruded on the privible havior towards or not directed toward than daily. The MD extensive assistant locomotion on/off unpersonal hygiene. The interview of the privible intruded on the privible havior towards or not directed toward than daily. The MD extensive assistant locomotion on/off unpersonal hygiene. The interview of the privible intruded on the privible havior towards or not directed toward than daily. The MD extensive assistant locomotion on/off unpersonal hygiene. The interview of the privible intruded on the privible havior towards or not directed toward than daily. The MD extensive assistant locomotion on/off unpersonal hygiene. The interview of the privible intruded on the privib	R21 which were over 430 ned she would have expected tending MD and/or the on-call with the Change in Condition the MD/NP/PA policy. related to physician d sugar fluctuations, entitled, in When to Report to the ter(NP)/physician assistant cluded: "blood sugars greater machine registers high) in ing sliding scale insulin should orted to the physician or nurse on 12/29/15, at approximately confirmed R6 was unable to inderstood, and staffing gestures and facial tic report indicated R6 was lity in 2014, with diagnoses without behavioral disturbance inmunication deficit. ssessment dated 10/9/15, in thad severely impaired wandering that significantly acy of others, physical thers 1-3 days, other behaviors others 4-6 days but less in Salso indicated R6 required the with bed mobility, transfer, init, dressing, toilet use, and The MDS further indicated nor family/significant other te the daily and activity	F3	809			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245378	B. WING		12	2/31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC	,		STREET ADDRESS, CITY, STATE, ZIP CO 200 EAST NINTH AVENUE LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	R6's care plan date falls related to (r/t) weakness, gait/bals incontinence, heari impaired cognition, needs. Intervention meet needs, encouexercise, physical a improved mobility, three times daily, rewall or objects, use The care plan furth problem r/t hearing Interventions including the resident/family concommunication diff were unable to conthe progression of effectiveness of coassistive devices. On 12/29/15, R6 w 1:16 to 4:17 p.m.: At 1:16 p.m. R6 w by two staff with a twheelchair (w/c) be "Cityside" hallway. while walking and a understood, spoke turn talked to the relength of the hall, the to the dayroom in fithen propelled hims his w/c.	ed 10/12/15, indicated a risk for history of falls, generalized ance problems, bladder ng and vision impairments, and difficulty communicating as included: anticipate and arage activities that promoted activity for strengthening and ambulate with staff in hallway edirect when wheeling close to a distraction when restless. er identified a communication deficit and head injury.	F3	09		

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F 309	-type cord enabling manipulated. R6 are loud constantly and the item but did not attempted to manipulated. At 1:34 p.m. a staff the middle of the daresident. R6 continusensory object reminteraction with staff remained at the tabbegan to propel him dayroom. -At 1:44 p.m. R6 stanurses' station. LPN away from the area room. -At 1:52 p.m. R6 properto the drinking foun had a plastic mugawater from the four approached R6 and mug with water themug. R6 accepted to mumble out loud west hallway toward. Once R6 made it to intercepted the resiroom. -At 2:00 p.m., R6 work covers without shoe resident was holdin legs. R6 eyes were	the object to be stretched and accepted the item, talking out NA- walked away. R6 held appear interested, nor did he oulate the object. If member transported R6 from ayroom to a table with another used to verbalize while the ained in his lap. No f and R6 was observed. R6 ale for a short time and then uself in w/c around the arted to propel behind the N-C redirected the resident and then assisted him to his and then assisted him to his opelled himself out of his room tain in the west hallway. R6 and was attempting to obtain tain. A staff member disassisted him with filling the in replaced the cover on the the water mug then continued and propel himself down the dis the administrative offices. In the end of the hallway, staff dent and returned him to his as lying in bed on top of eas. A sensory item the given a service of the resident's	F3	609			

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F 309	on his lap. The resident paying attention to the paying attention to the content of the paying attention to the content of the paying attention to the	ng, and the sensory item was dent was not touching or the sensory object. as seated on the edge of his was off his foot, as he held his	F3	09		

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F 309	following times: - At 7:50 a.m. R6 with ecorner of the diindependently. The wall on two sides. Fresidents as he factory as the Cityside dayr table. Staff handed shaped sensory ob when manipulated, without further interbehind him on the sto propel himself pathe dining room to LPN-C was standing understood, he voo R6 he had already resident back to his resident's room at 8 bare mattress and The bedding was powas holding onto the propel himself of the brakes locked. In located on the seat was wearing shoes the side of the room surveyor alerted the walking by to quest of independent amiliary.	as seated alone at a table in ning room eating breakfast table was pushed flush to the R6's back was to the other ed the wall. Tas assisted in the w/c by staff room and was situated at a R6 a multicolored cylinder ject that also made sound Staff then left the area raction. R6 placed the object seat of his w/c and proceeded ast the nurses' station towards the medication cart where g. Although R6 could not be alized loudly. LPN-C informed eaten and assisted the scroom. LPN-C left the R:05 a.m. R6 was lying on the pillow without a pillowcase. Illed at the end of the bed. R6 the grab bar, attempting to sit as seated at the edge of the spositioned next to bed with R6's tennis shoes were of the w/c. At 8:36 a.m. R6, and was ambulating along in as he felt the wall. The eadministrator who was ion whether R6 was capable outation. The administrator etimes ambulate, and	F 30	9		

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	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, Z 200 EAST NINTH AVENUE LAMBERTON, MN 56152	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE
F 309	administrator asked oxygen (O2) as he oxygen (O2) as he occupying a substitution of the activity room. Resulting a substitution of the east hallway. R6 then enhimself around the to look out the wind fish tank. R6 propel direction of the east here until 10:30 a.m. the east hallway to dayroom. No verbainteraction was noted. At 11:07 a.m. R6 who you nurses station. And was identified or planned intervention seated in w/c in City station when the act dayroom, said "Hi" on the TV and walk remained seated at the coxygen of the total c	If R6 whether he needed his was heavily breathing. The a nasal cannula and the e room. The anasal cannula and the eroom. The anasal cannula and the eroom. The anasal cannula and the eroom.	F3	09		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	R6 to ambulate, ho stand when prompt seconds. The transtaff left the resider -At 2:35 p.m. R6 with emen's group acarea of the dining rwhile located in the room, partitioned or R6 was offered his routinely had been from the other resides nacks in the main when R6 finished haround the front are designated table. The was assisted out the direction of his interviewed on 12/3 cited a communicate with attempted any alter unfair to R6. TMA-approximately mon When interviewed of licensed social worthey were unsure wable to talk to his fa Although they had to contact his family attempting.	and NA-A attempted to assist wever, the resident did not sed for approximately 30 sfer belt was removed and the nt. as in the dining room where stivity was held in the main soom. R6 was served a snack front area of the main dining ff by a wall with two openings. snack at the table where he served meals, alone and away dents who were served their dining area. At 2:41 p.m. is snack, propelled himself as of the dining room near his No staff interacted with R6 until at of the dining room towards froom at 2:44 p.m. When 30/15, at 12:41 p.m. the AD tion barrier. On 12/20/15, at 3:36 p.m. ey were unable to the resident and had not mative method, and said it was A said R6's family visited	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 309 F 325 SS=D	returned to his room wandered. The DO informed the reside a bare mattress, lin bed, and no pillowo agreed staffs' interva appropriate interver	R6 should not have been or put into bed when he N stated, "That's sad" when nt had been put into bed with en pushed to the end of the ase on the pillow. The DON rentions and/or lack of hitions were concerning.	F 309			2/8/16
	resident - (1) Maintains accept status, such as boot unless the resident demonstrates that the state of the s	otable parameters of nutritional by weight and protein levels, s clinical condition his is not possible; and apeutic diet when there is a				
	by: Based on observatoreview, the facility for were implemented loss for 1 of 3 residuntritional status. Findings include: R28's physician ord	ion, interview and document ailed to ensure interventions to prevent significant weight ents (R28) reviewed for ler sheet dated 7/1/15, including stroke, chronic dementia.		The preparation of the following placorrection for this deficiency does not constitute and should not be interprated as an admission nor an agreement facility of the truth of the facts allegated conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was expected by because provisions of state at federal law require it. Without waive foregoing statement, the facility state with respect to:	reted by the ed or ent of n ecuted and ing the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245378	B. WING			12/3	31/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	12/	71/2010
VALLEY	VIEW MANOR HCC				AMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	The quarterly Minin 12/11/15 revealed in the past month or 1 residents current we eating problems. Thad experienced a from the previous in significant change. Review of the most R28 as having pote to dementia and delinterventions listed residents meals, more port any changes residents weights a significant weight in to eat in a calm set. Review of R28's log loss from 170 to 15 (3 month period). Review of R28 nutron 10/14/15 indicates 170#. The resident his meals and is on or swallowing problems and has not declined weight loss of 20# in risk for malnutrition documented related interventions related.	num Data Set (MDS), dated R28 had a weight loss of 5% in 0% in the past 6 months. The eight at 150#. No chewing or ne MDS further identified R28 weight loss of 20# pound (lb) MDS dated 9/16/15, of a current care plan identified ential nutritional problems due creased cognition. include: staff assist to set up onitor the residents intake and to the physician, monitor the nd report to the physician any loss and allow the resident time ting. In of weights revealed a 20 lb of lbs. between 9/15 and 12/15 itional assessment dated the residents weight was at eats an average 75-100% of a regular diet with no chewing	F3	325	1. Resident #28 had his diet revie a licensed dietician and changes maccording to his clinical needs. 2. Residents showing weight loss residents were reviewed for weight had their dietary needs reviewed by licensed dietician and any changes that were necessary to improve the clinical profile with regard to nutrition. 3. Education will be completed on at an all staff meeting to ensure the interventions are implemented to posignificant weight loss. 4. The Interdisciplinary Team will weekly to review and discuss weight and interventions for nutritional serong the dietary manager will document interventions for nutritional concern MDS Coordinator will do an audit word for 2 months to ensure that the nut concerns of residents are being fol. 5. The data collected will be reviewed/discussed at the quarterly meeting. At this time the QA&A committee will make the decision/recommendation regarding follow-up studies. The Dietary Manager and MDS Coordinator will be responsible for POC. Completion Date: 2-8-16	(all loss) y a made eir on. 1 2-5-16 at revent meet nt loss vices. t new loss. The veckly ritional lowed. y QA&A g any	

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	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CO 200 EAST NINTH AVENUE LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 325	meals. Average da The residents food resident had an incithe months of 11/15 R28's most current completed by the difference to the resident's significated to the resident requiring more assistant. No recommoduring interview with 12/29/15 at 2:00 p. of who was responsible to the resident most current MDS triggered/identified The DD stated R28 discussed with the	takes ranging from 0-100% at ily intake of food is 25-50%. intake log revealed the reased decline in eating for 5 and 12/15. dietary progress note, ietician on 12/15/15, indicated ficant weigh loss may be ents increased dementia and istance with setting up his endations were provided. th the dietary director (DD) on m., indicated she was unsure sible for monitoring R28's ned she had completed the	F3	25		
	12/30/15, at 8:00 a resident his meal. This meal but did no The resident received.	s of R28 eating breakfast on .m. staff were feeding the The resident consumed 90% of t participate in the process. ved a regular mechanical soft g or swallowing problems.				
	at 8:00 a.m. she co R28's significant we nursing staff indica probably due to his more assistance we included she did no	th the facility RD on 12/30/15, onfirmed she was aware of eight loss and stated the ted R28's weight loss was dementia and he required ith eating. The RD further of recommend any type of commendation for R28's weight				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245378	B. WING		12/:	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325 F 465 SS=D	being within normal stated she was not weight loss if they follow up the following questioned, the RD weight loss should staff for causal factorinterventions. 483.70(h) SAFE/FUNCTIONALE ENVIRON The facility must prosanitary, and comfor residents, staff and	dents body mass index (BMI) ranges. The RD further concerned about a residents all within their BMI, but may ng month. When further did confirm R28's significant have been addressed by the ors and follow up AL/SANITARY/COMFORTABL Divide a safe, functional, ortable environment for	F 325			2/8/16
	by: Based on observation failed to ensure 1 or reviewed with floor sheet rock that was Findings include: During observation on 12/31/15, at 8:30 hole approximately sheetrock at the basis adjacent to the turburing observation at 8:35 a.m. the mathe damaged wall in He stated, "tub has	ion and interview the facility f 5 rooms (Room 109, R6) or wall damage had bathroom maintained in good repair. of bathroom in room 109 (R6) 0 a.m. it was noted to have a 15 inches by 4 inches in the se of the bathroom wall which		The preparation of the following placorrection for this deficiency does reconstitute and should not be interplated as an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was exsolely because provisions of state a federal law require it. Without waive foregoing statement, the facility state with respect to: 1. Resident #6 bathroom wall was repaired by maintenance. 2. All resident is rooms were obsited for damage to walls and repairs maineeded. 3. Education was completed at an	reted t by the ed or ent of n ecuted and ving the ites	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245378	B. WING			12/3	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC			20	TREET ADDRESS, CITY, STATE, ZIP CODE DO EAST NINTH AVENUE AMBERTON, MN 56152		.,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	tub room was adjace maintenance directs size hole in the wall dispenser and agreedid not create a hormaintenance direct policy/procedure but the maintenance direct policy but the maintenance direct policy but the maintenance direct policy but	cent to R6's bathroom. The or further confirmed a quarter below the toilet paper ed the areas in the bathroom melike environment. The or could not provide a ut indicated staff would fill out a poard when there was a	F4	.65	staff meeting on 2-5-16. Staff wer informed to notify the maintenance director immediately when they see that are damaged and need repair maintenance was in-serviced on the to provide repairs for the aesthetic enjoyment of the residents. 4. The Maintenance director will of weekly walk through checking for of in rooms for 1 month and then birm for 2 months and then monthly to ethat the facility does not have any venced of repair. 5. The data collected will be reviewed/discussed at the quarterly meeting. At this time the QA&A committee will make the decision/recommendation regarding follow-up studies. The Maintenance Director and Administrator will be responsible for POC. Completion Date: 2-8-16	e things and e need do a lamage nonthly nsure valls in / QA&A	

PRINTED: 02/01/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 **B WING** 12/29/2015 245378 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 EAST NINTH AVENUE VALLEY VIEW MANOR HCC LAMBERTON, MN 56152 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

01/29/2016

(X6) DATE

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.

Facility ID: 00731

PRINTED: 02/01/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A: BUILDING 01 - MAIN BUILDING 01 B. WING 245378 12/29/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 000 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

(X2) MULTIPLE CONSTRUCTION

PRINTED: 02/01/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION 12/29/2015 B. WING 245378 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 EAST NINTH AVENUE VALLEY VIEW MANOR HCC LAMBERTON, MN 56152 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 000 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: 1/4/16 K 025 K 025 NFPA 101 LIFE SAFETY CODE STANDARD SS=D 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: 1. Maintenance caulked with fire barrier Based on observation, the facility failed to caulk the penetration breach in the maintain smoke barrier wall in accordance with southwest hallway and checked the other the following requirements of 2000 NFPA 101, smoke barriers for possible breach. Section 19.3.7.3, 8.3.2 and 8.3.6. The deficient practice could affect 12 out of 40 residents. 2. The completion date was 1-4-16. Findings include: 3. The Maintenance Director is

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY LETED
	PROVIDER OR SUPPLIER	245378	B. WING	S1 20	TREET ADDRESS, CITY, STATE, ZIP CODE DO EAST NINTH AVENUE AMBERTON, MN 56152	12/29/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 025	On facility tour beto on 12/29/2015, obs smoke barrier in the open penetration a barrier doors above	ween 11:00 AM and 1:00 PM servation revealed that the e Southwest Hallway has an round cables above smoke the lay in ceiling.	K	025	responsible for this POC and monit to ensure that this deficiency does reoccur.	oring not	
K 038 SS=E	Facility Maintenand discovery. NFPA 101 LIFE SA	tice was confirmed by the ce Director (RP) at the time of AFETY CODE STANDARD nged so that exits are readily nes in accordance with section	K	038	ii le		1/8/16
	Based on observation facility failed to produce with the 2000 NFPA 101, S 7.2.1.6.1(d) and the	is not met as evidenced by: ation and staff interview, the ovide means of egress in ne following requirements of section 19.2.1 and 7.2.1.5.4, e 2007 MN State Fire Code, eficient practice could affect 20			Maintenance replaced the MAG board to the East exit door on 1-8-The Maintenance Director will ched doors for proper functioning weekly month and then monthly. The completion date was 1-8-	16. ck the y x 1	
	on 12/29/2015, ol	ween 11:00 AM and 1:00 PM oservation revealed that the Exit did not function properly.			The Maintenance Director is responsible for this POC to ensure exits are readily accessible at all till.	e that mes.	

PRINTED: 02/01/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE COMP		SURVEY					
		245378	B. WING			12/2	9/2015
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE AMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 038	door handle for 30 disengaged so that under all circumsta This deficient pract	not disengage after pushing on seconds. System was the door could be opened	K	038			
							*

Event ID: ZNOX21



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.

Valley View Manor HCC January 20, 2016 Page 2

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

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

(X6) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		ATE SURVEY DMPLETED	
		00731	B. WING		12/3 ⁻	1/2015	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE			
VALLEY	VIEW MANOR HCC		NINTH AVE	_			
			ON, MN 56		ON.		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000				
	*****ATTEN	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surve found that the deficit herein are not corrected shall I	Minnesota Statute, section order has been issued y. If, upon reinspection, it is iency or deficiencies cited octed, a fine for each violation oe assessed in accordance ines promulgated by rule of artment of Health.					
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of black of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. It is several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was					
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.					
	of this Department's provider and the fol issued. When corre sign and date, make return the original to	PS: 19, 30, and 31 2015 surveyors a staff, visited the above lowing correction orders are ections are completed, please a copy of these orders and the Minnesota Department of Compliance Monitoring,		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware.		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 01/29/16

TITLE

STATE FORM 6899 If continuation sheet 1 of 64 ZNOX11

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
7.1.12 . 27.1.1	G. GG2G.1.G.		A. BUILDING:			
		00731	B. WING		12/3	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE FON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	Licensing and Certi	fication Program; 12 Civic 2105, Mankato, Minnesota		The assigned tag number appears far left column entitled "ID Prefix The state statute/rule number and corresponding text of the state state out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met at evidenced by." Following the survividenced by." Following the survividence of the Suggested Method Correction and the Time Period Following the survividence of the Suggested Method Correction.	Fag." the tute/rule ies" ply" nis s which after the s veyors d of	
				PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TFEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTAS' STATUTES/RULES.	THIS ON FOR	
2 265	MN Rule 4658.0085 Resident Health Sta	5 Notification of Chg in atus	2 265			2/8/16
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death.	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an				

Minnesota Department of Health

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00731	B. WING		12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE FON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 2	2 265			
	development of the	must be involved in the se policies. The policies must address at least the tion times for:				
		involving the resident which I has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ration in health, mental, or in either life-threatening al complications;				
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				
	D. a decision t resident from the no	o transfer or discharge the ursing home; or				
	E. expected an	d unexpected resident deaths.				
	by: Based on interview facility failed to notification with the control of the co	and document review, the fy the physician in a timely esidents (R46, R21) reviewed who experienced significant in requiring medical treatment. Usual harm for R46, who ged discomfort, dehydration ed to delayed physician is sequent transfer to an a small bowel obstruction.		Completion Date: 2-8-16		
	Findings include:					

6899

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP		SURVEY PLETED
		00731	B. WING		12/3	31/2015
	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 3	2 265			
	dated 9/17/15, iden improving with orde occupational therape R46's physician's prindicated diagnoses lumbar region, sepson The physician's prohistory of diverticuling R46's admission Mig/24/15 identified a Status score of 13/2 area assessments of R46's care plan, da cognitive impairment return to the common R46's September 2 revealed R46 had refour times on that decided 2:00 a.m. on 9/26/1 licensed practical in the medication administered on 9/2 the medication had since supper. No feeffectiveness was considered in the feet of the support of the support of the support.	rogress notes, dated 9/18/15 is of spinal stenosis of the sis, and urinary tract infection. It is of the colon. Inimum Data Set (MDS), dated Brief Interview for Mental 15 (cognitively intact). No care were completed with the MDS. Ited 9/30/15 identified no into and that R46 desired to unity. O15 medication sheets eceived Maalox (an antacid) is (cc)'s on 9/25/15 a total of late, as well as one dose at 5. Notations documented by urse (LPN)-A, on the back of linistration record for a dose 25/15, at 2:00 a.m. indicated been given for stomach upset completed. A subsequent				
	had received anoth- stomach and emes listed as had anothe the other doses addresults documented	, at 2:00 am. indicated R46 er dose of Maalox for an upset is; the follow up result was er emesis at 4 a.m. None of ministered had follow up d. note written by LPN-F on				

Minnesota Department of Health STATE FORM

E FORM SNOX11 If continuation sheet 4 of 64

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 12/0	172010
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 265	9/25/15 at 8:30 a.m and complaints of rindicated R46 had la along with Thorazin after his morning made experienced a the bed and himsel anything for breakfa orange juice that had a nursing progress on 9/25/15, at 1:39 large emesis, and the was not feeling well hiccups had subsidicted started again. Doctoreceived Maalox are medication used for another small emest documented as have and was described R46's temperature been elevated at 95 and and was described R46's temperature been elevated at 95 and most of the evening hiccups were better but that R46 had be feel right and that we to gag. R46 had easips of water. Addit indicated a fax (fact medical doctor (ME) condition including temperature at 99.5 feeling chilly.	a., indicated R46 had hiccups not feeling well. The notes oeen given Maalox 30 cc's nee and had begun retching redications. In addition, R46 large projectile emesis all over f, and had refused to eat nest, stating he had consumed	2 265			

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 265	feeling well, and had emesis twice on the appear to have a felbeen given to help witamins had been I. A nursing progress at 1:56 a.m. indicated distended, his bower and he had been h	d been having brown colored afternoon shift which did not ces odor. Maalox 30 cc's had with hiccups and R46's neld due to emesis. note by LPN-A, dated 9/26/15, ed R46's abdomen was el sounds were difficult to hear aving emesis which looked like as noted to be slightly elevated note written by LPN-A on a indicated R46 had 100 cc's formed/loose BM (bowel odor. The note further cool and clammy, with a inperature at 99.1 degrees F. sket beside him, and to transfer R46 had two reenish liquid thick with pieces in addition, the note indicated ital had been called and an to transfer R46 to their incitated ital had been called and had at the hospital. R46 left the corder dated 9/26/15 was cord and verified the physician in ambulance to the acute care	2 265			
		ng progress note dated				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: COM		SURVEY PLETED	
		00731	B. WING		12/3	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC	200 EAST	DRESS, CITY, S NINTH AVE TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 265	admitted to the acurdiagnoses of bowel surgery. A faxed physician's p.m. from the facilitidentified that R46 rexperienced severathroughout the day drink. R46 complainad not been signedays later, when the responded with a stelephone order to the Please do NOT fax need attn [attention [physician] - today staing for response. The ER progress notes a.m. was reviewed. The ER progress notes a.m. was reviewed. The ER note further was firm and diffuse with dried brown material The ER notes further was firm and diffuse with no appreciable 1800 milliliters (ml) drained from R46's a nasogastric tube. normal saline intraventation physician's note individual and diagnoses of small dehydration. The ER registered in the surgest of the total control of the total contr	te care hospital with a obstruction, and would need order sent on 9/25/15, at 6:05 y to R46's primary physician nad emesis since 8:30 a.m.,	2 265			
	he'd been vomiting	for the last two days and his own like stool. R46 had				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED	
		00731	B. WING		12/	31/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		T NINTH AVEN TON, MN 561	=		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 265	the ER and the vombrown liquid running abdomen was very and the pain. R46 nasogastric tube for fluid output after who teter. R46 was allow what ever we have The hospital dischaindicated R46 had used to correct the small developed subsequanticoagulation is suileus (disruption in surgery. The ileus of a nasogastric tube were initiated and Fouring interview on director of nursing (expected staff to commediately with the specially when the BM-type material and During interview on nursing home's head coordinator/nursing LPN-B was not well hospital intensive contention interview. The HIM pool nursing staff. During interview on acting administrator administrator administrator administrator.	in the ambulance enroute to nit was described as dark gout of his mouth. R46's firm, with no bowel sounds was distended. R46 pminal pain but was unable to had his stomach drained via a reten minutes with 1400 mL of nich R46 stated he felt much ert and "states we should do to do. Is comfortable now." Targe summary dated 10/5/15, undergone abdominal surgery bowel obstruction, and had lent cardiac and less as well as post-operative normal bowel motility) after the resolved with the replacement pe; however, comfort cares R46 passed away on 10/5/15. 12/29/15, at 3:07 p.m. the DON) verified she would have ontact the on-call doctor e urgent clinical issues, a resident was vomiting and not feeling better.				

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Minnesota Department of Health

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
		00731	B. WING		12/3	31/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•		
			NINTH AVE				
VALLEY	VIEW MANOR HCC		ON, MN 56				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE	
2 265	Continued From pa	ge 8	2 265				
	hospital with a bowelater been found to administrator was uregarding R46's epistated she would had contact/call the onedirectly with concert administrator stated staff to check the vistatus, appetite and a physical assessm she thought LPN-A her judgment. She every Thursday night						
	on 12/29/15 at 4:02 received report from on 9/25/15, regarding been unaware a fax stated she'd worked prior and was aware complaints of not feel She was aware R46 been eating well, an administered Maalox first time she admin LPN-A verified R46 like stool but there was abdomen had also subsequently vomit later in her shift (are she'd become concomething wrong waid she'd proceeds						

Minnesota Department of Health

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURV COMPLETE	
		00731	B. WING		12/3	31/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		T NINTH AVE TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 265	not call the RN on cher concern. LPN-along the paperwor nurse, LPN-B, who on 9/26/25. LPN-A an assessment to for During the interview there had been a his she had noted when pass along to the distance of the pass along to the distance of the physicial symptoms, and that there had been a disphysician notification. During interview on medical director was would have expected they filled out the past the hospital. The malthough R46 may hanyway, prompt men him comfortable. The effect of delayed more related to R46's mental to R46's mental the state of the would have called the clinic and R46 began vomiting stated faxing medicing p.m. was inappropring the along the concerned the conce	call nor notify the physician of A indicated she had passed k and her concern to the day arrived on duty at 6:00 a.m. stated she'd told LPN-B to do ollow up on R46's condition. at LPN-A stated she thought story of small bowel concerns in filling out the paperwork to ay shift personnel. Interview on 12/30/15, at 9:12 tor stated LPN-A should have an sooner about R46's t she had not been aware elay in his nursing care and	2 265			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	ETED
00731 B. WING 12/31/2	/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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE
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 (ie. 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 Recular Human Solution 100 unit/milliliter	

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		SURVEY PLETED
İ		00731	B. WING		12/3	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC	200 EAST	DRESS, CITY, S NINTH AVEI TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 265	(ml) Inject as per sl ordered dosage "gr units". A physician's order, Insulin Glargine Sol subcutaneous (SQ) sliding scale with R unit/ml. BS reading diabetic educator w listed for notification hypo (low) or hyper During interview on licensed practical newer no protocols, notify the medical dutential the protocols of the prot	ge 11 iding scale with the final eater than 400 mg/dL: give 6 dated 12/7/15 indicated, lution 100 unit/ml- 24 units one time per day (QD), and egular Humalog solution 100 gs were to be faxed to the reekly. No parameters were not the physician regarding (high) glycemia (BS). 12/30/15, at 3:10 p.m. a urse (LPN)-C indicated there or orders, indicating when to loctor (MD) of BS levels. would notify the MD related to lit and if there was a high ified as "way above 400's- 6 p.m. LPN-D stated she of she obtained a BS result LPN-D confirmed on er BS check for R21 was 521 was not updated. LPN-D frequently has BS readings and the facility standing orders of regular insulin if the BS of mg/dL. LPN-D indicated er read "high" it was the result g/dL and she would telephone the hospital to report the	2 265			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 12/0	.,
			NINTH AVE	•		
VALLEY	VIEW MANOR HCC		ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	adjustments and the were based upon. Stated R21 had a heard nursing staff were medical provider or related to changes educator further incomparameters had be recently discharged 12/5/15. She indicated have been determing During interview on and RN-C stated the for reporting BS read documentation on the and stated that would followed unless indivitten. RN-B indicated symptomatic she were based on the stand and RN-C indicated Change in Condition reporting of BS read RN-B stated, "we were everyone is aware of During interview on indicated she had a months at the faction BS checks which area, wear gloves, resident had orders specific insulin order specific insulin order in the R21 LPN-E indicated ordered SS dose and and recomposition. In the R21 LPN-E indicated ordered SS dose and red in the recomposition of the reading she was a specific insulin ordered SS dose and red in the R21 LPN-E indicated ordered SS dose an	is was what insulin changes The diabetic educator further istory of being a brittle diabetic ere supposed to call the call and/or the triage nurse in status. The diabetic licated she thought BS en identified when R21 was from the the hospital on ated the parameters would ned by the discharging MD. 12/30/15, at 3:12 p.m. RN-B ere were facility parameters adings. They referenced the he facility's standing orders ald be the practice they ividualized orders were ated if a resident was ould notify the physician ing order instructions. RN -B I they were not aware of the n policy related to immediate dings above 430 mg/DL. ill have to make certain	2 265			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 13	2 265			
	stated she would po this instance as this fluctuations. LPN-E	robably not notify the MD in s resident has a history of BS E further indicated R21 did not s for follow up but this is what				
	the facility's medical resident would have from the hospital for physician stated R2 before admission to history of blood sugthat the resident was when her blood sughowever, stated if so for an elevated blood provide specific orderequired to recheck results. She stated, 'hi' because they have blood sugar is below to initiate the hypogindicated she would and/or on-call staff were outside range.					
	director of nursing of 2015 documentation indicated she was used of BS readings for larged. She confirm staff to notify the at staff in accordance	on 12/31/15, at 1:00 p.m. the (DON) reviewed the December n of R21's BS readings and unaware of the wide fluctuation R21 which were over 430 med she would have expected tending MD and/or the on-call with the Change in Condition the MD/NP/PA policy.				
	notification for bloo	related to physician d sugar fluctuations, entitled, n When to Report to the				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	MD/nurse practition last revised 3/15, in than 430 mg/dL (or diabetic patients us be immediately repersectioner (NP)." SUGGESTED MET director of nursing (develop, review, an procedures to ensurphysician in a timely condition changes a needs. The director could educate all apand procedures. The designee could devensure ongoing contat the quarterly QA&TIME PERIOD FOF (21) days. MN State Statute 14 or related disorder to ALZHEIMER'S DISDISORDER TRAIN MN St. Statute 144.	er(NP)/physician assistant cluded: "blood sugars greater machine registers high) in ing sliding scale insulin should orted to the physician or nurse (HOD OF CORRECTION: The DON) or designee could d/or revise policies and re the facility notifies the y manner when the resident's and according to individualized of nursing (DON) or designee opropriate staff on the policies in director of nursing (DON) or elop monitoring systems to inpliance and review findings and meetings. R CORRECTION: Twenty-one 44.6503 Alzheimer's disease train EASE OR RELATED ING: 6503	2 265			2/8/16
	Alzheimer's disease or related of segregated or gene care staff	d training include:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00731	B. WING 12/		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
2 302	(1) an explanation of related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent topics covered. (d) The facility shall this section. This MN Requirements by: Based on interview facility failed to provinterested family meaning, how often, training provided.	of Alzheimer's disease and activities of daily living; with challenging behaviors;	2 302	Completion Date: 2-8-16		
	Findings include:					
	consists of all requi	neimer's training program red elements, staff are trained tively impaired on new hire al module each quarter related neimer's care.				
	provided to resident admission to the fa	mission forms and documents ts and their families upon acility indicated there was no and Alzheimer's training.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. Bolesina.			
		00731	B. WING 12/3		12/3	31/2015
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 16	2 302			
	director of nursing (information with the they are not providing consumers related indicating they will surple sur	on 12/30/15, at 3:15 p.m. the DON) stated she reviewed the administrator and verifieding written information to to Alzheimer's training start "working on it". THOD OF CORRECTION: The ould review their policies and ion to insuring updated provided to residents and/ording Alzheimer's/Dementia of training/notification could the quarterly QA&A meeting.				
2 565	Plan of Care; Use	Subp. 3 Comprehensive	2 565			2/8/16
	must be used by all care of the resident This MN Requirement by: Based on observati	personnel involved in the . ent is not met as evidenced on, interview and document		Completion Date: 2-8-16		
		illed to follow the plan of care for 2 of 3 (R6, R23) residents es.				
	-					
	When interviewed of	on 12/29/15, at approximately				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00731	B. WING		12/3	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC	200 EAST	DRESS, CITY, S NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 565	8:50 a.m. the direct R6 did not speak or further indicated staresident through ge R6 was admitted to diagnoses including disturbance, cognitic chronic obstructive muscle weakness a facility diagnosis related the reside but occasionally nestructuring leisure a wellness. Intervent plan: (1.) CD player in rocresident's desire. (2.) Recreation/We exercise, listening twestling and warm sensory and 1:1 tim (3.) EMOTIONAL: individual music enj (4.) PHYSICAL: Er Well-Fit program to individual cardio. The would work on puzz period. On 12/29/15, R6 was 1:16 p.m. until 4:17 - At 1:16 p.m. R6 was residents wheelcha west cityside hallwas	or of nursing (DON) confirmed or understand English. DON aff communicated with the stures and facial expressions. the facility on 9/5/14, with generatia without behavioral ve communication deficit, pulmonary disease (COPD), and difficulty walking per the port. activities dated 10/12/15, and was primarily independent eded some guidance with activities that promote ions identified on the care form; please play music per ellness preferences include: or music, watching TV (enjoys novies) food related activities, i.e. Offer ipod or CD player for ion include group exercise and/or ne activity goal indicated R6 eles in day room by the review as observed continuously from	2 565			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00731	B. WING		12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	the dayroom area lo Staff moved him in R6 propelled himse dayroom. -At 1:27 a.m. nursing a round shaped sermultiple-colored hold bungy type cord. The stretched and manifem, talking out loud held the item, he did he attempt to manife NA-A left the area at R6. -At 1:34 p.m. a staff the middle of the dayresident. R6 continues sensory object remained at the tab began to propel the continues of covers with segiven to him earlier was not touching not though he appeared time, a popcorn and in the activity room. -At 2:07 p.m. it was on edge of bed with sensory item remained.	er belt and transferred him to ocated by the nurses' station. front to the television and then elf in the w/c throughout the engassistant (NA)-A brought R6 insory item which consisted of ellow tubes held together with a his enabled the object to be pulated. R6 accepted the eld constantly. Although R6 defended not appear interested nor didevalate or pull the sensory item. Effect the item was delivered to elivered to elivered to verbalize while the elimed on his lap. No ele a short time and then elivered to elivered. R6 form ayroom to a table with another elivered to verbalize while the elimed on his lap. No elle a short time and then elivered elivere	2 565	DELIGITION)		
	-At 2:14 p.m. staff e	entered the room to distribute				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00731	B. WING		12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 19	2 565			
	fresh water, greeted	d R6 and left immediately.				
	bed in room with the a shoe on his lap, re sensory object was music was playing i					
	the bed attempting shoe. R6 had a nel were present in the	emained seated at the edge of to pull the laces from his left bulizer mask on and no staff room during this observation. Ford games activities were soom at this time.				
	attending to the net continued to sit on a remove the laces fr R6 remained seate onto the unlaces let entered the room a medication aide (TN and asked whether shoe". NA-C aske supposed to have to that if NA-C could go could transfer him in about it. On 12/29/seated on the side without laces. R6 as shoe. The Wellness schedule for 4:00 p seated on edge of the shoe. This active 2:30 p.m. (almost 2)	,				
		/assisted to scheduled 3 hours of continuous				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00731	B. WING		12/3	31/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
VALLEY	VIEW MANOR HCC		' NINTH AVE FON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	observation on 12/2 not followed as writ sensory object thou object could be use with R6. It was observed on church activity was room. R6 independ the west hallway but the administrator reback down the direct entered the dayroor perimeter of the arewindow and then wittank. R6 propelled seast hallway and reuntil 10:30 a.m. LPI east hallway to a tank No verbal communinoted between staff offered/assisted to throughout the note interact with the result of the seast hallway to a tank offered/assisted to throughout the note interact with the result of the seast hallway to a tank offered/assisted to throughout the note interact with the result of the seast hallway to a tank offered/assisted to the s	29/15. The plan of care was ten. R6 was handed a algh staff failed to model how ad and/or spend time any time 12/30/15, at 10:04 a.m. a conducted in the activity ently propelled himself down at once R6 turned the corned, edirected and propelled him ction of the hallway. R6 then m, propelling self around the ea, pausing to look out the atched the activity in the fish self toward the direction of the emained seated near this area N-C then moved R6 from the ble located in the dayroom. ication nor interaction was f and R6. R6 was not the church activity at anytime ed observations nor did staff	2 565			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		- -
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	with 2 openings. R table where he rout R6 was left alone in room while the other snack in the main a finished his snack, front area of the dintable. No activity st R6 until they assiste towards the direction. When interviewed a AD stated R6 is ver and is scheduled for further indicated that were scheduled for stated staff will also well as the men's grandless the	ge 21 6 was offered his snack at the inely consumed his meals. In the front area of the dining er residents were served their area. At 2:41 p.m. when R6 propelled himself around the ining room near his designated aff were noted to interact with ed out of the dining room on of his room at 2:44 p.m. In 12/30/15, at 12:41 p.m. the ry "antsy" r/t group activities or in-room programming. AD at 2 in-room activity programs 20 minutes/day. AD also offer coffee social time as roup activity as well as three about the preferred activities movies) documented on R6's ated being unaware of these in the current activity sheets abstantiate the activities each ed, there was nothing documented indicating that R6 in activities during the days of iewed on 12/31/15, at 10:21 and 10 days of December 2015 in indicated R6 was offered at 10 days. AD stated the 12/21/15, indicated the did the exercise activity. AD to R6 during the activity and However, the AD was unable to	2 565			
	November 2015 an	tion of activities offered in d provided 5 days of activity 2015. It was confirmed the				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/2	1/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	12/3	1/2015	
	VIEW MANOR HCC		NINTH AVE				
			TON, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 565	Continued From pa	ge 22	2 565				
	plan of care was no	t implemented as written.					
	including: dementia disorder, and chron disease (COPD) pe The report further in	on 1/6/15 with diagnoses paranoid personality, mood ic obstructive pulmonary or the facility diagnosis report. Identified R23 was admitted to 15/15/15 due to senile brain.					
	resident was dependent and providing activition due to concluded: (1) "1 to activities if [resident of room events. (2) participation in smainteractions (3) EM player for individual ENVIRONMENTAL body language relations [Resident name] Repreferences included	trevised 11/9/15, indicated the ident on staff for structuring ties that promote wellness cognitive deficits. Interventions 1 bedside/in-room visits and tname] is unable to attend out COGNITIVE: Encourage Ill groups and/or 1:1 IOTIONAL: Offer ipod or CD music enjoyment. (4): Observe [resident name] ted to overstimulation ecreation/Wellness individual e Bingo, walks, magazines, and listening and playing music."					
	from 1:14 p.m. until A popcorn and mov p.m. in the activity r activity held at 2:30	continuously on 12/29/15, 3:56 p.m. while lying in bed. re activity was held at 1:30 room and the coffee social p.m. in the dining room. Staff e opportunity to attend either					
	12/30/15, from 10:0 10:03 a.m. R23 was cityside dayroom at	erved continuously on 03 a.m. until 10:23 a.m. At a seated in a geri chair in the a table while a church service held in the activity room.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE FON, MN 56			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 565	Continued From pa	ge 23	2 565			
	eyes closed. The Aresident seated in wonurses station and attend church. R2: AD and the residen away and closed he area. NA-A then apto ask whether she nodded "yes". NA-opportunity to attentransporting her to least the area. At 11:08 a.m. R23 weyes closed while a	was observed lying in bed with Wellness activity was in not been given the opportunity				
	closed. A music ac the cityside dayroor member piano play	as again lying in bed with eyes stivity was being performed in m with a resident's family ing. Staff were not observed to the activity to R23.				
	NA-B and NA-A cor with her morning ca activities, she often down. Both NA's of R23 attendance at R23 had been tearf	on 12/30/15, at 11:55 a.m. of the street of the morning church activity as full that morning when they felt the resident would				
	AD stated R23's ac daily Sunshine grou implemented twice on Saturdays). AD	on 12/30/15, at 1:40 p.m. the tivities included hair care, a up (sensory group) which is daily Monday-Friday and once confirmed she would still red the opportunity to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	12/3	1/2013
	VIEW MANOR HCC		NINTH AVE			
VALLET	VIEW WANON HCC	LAMBERT	TON, MN 56	152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	participate in attendicated documentaring provided for Rindicated R23 was attimes/weekly. AD provided for Rindicated R23 was attimes/weekly. AD provided 10 from 11/2/15 - 11/22/15 7 occasions during 11/12/15, 11/13/15, When interviewed to AD provided 10 day sheets for 23. The offered activities on unable to provide doffered in Novembe activity sheets for Cosheets did not incluinad participated or confirmed the chart incomplete. The plaimplemented as write SUGGESTED MET The director of nurs develop, review, an procedures to ensure plans according to the needs. The director could educate all agand procedures. The designee could devensure ongoing corrections.	ding church. AD attempted to tion of activities attended and 123. The 1:1 activity sheets to have 1:1's three provided 1:1 documentation (15 (minus the week of); R23 was provided a 1:1 on this period (11/5/15, 11/7/15, 11/27/15, 12/4/15, 12/7/15). In 12/31/15, at 10:21 a.m. the period of December 2015 activity sheets indicated R23 was a 5 of the 10 days. AD was ocumentation of activities er 2015 and provided 5 days of December 2015. The activity de evidence if the resident refused the activity; AD ting of activities was an of care was not	2 565			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/3	31/2015
	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
VALLET	VIEW MANOR FICE	LAMBERT	TON, MN 56	152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 25	2 830			
2 830	Proper Nursing Car	O Subp. 1 Adequate and re; General general. A resident must	2 830			2/8/16
	receive nursing care custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident				
	by: Based on interview facility failed to provand services for 2 creviewed who had be resulted in actual haprolonged discomfor related to delayed ransfer to an inpatiobstruction. In add provide appropriate			Completion Date: 2-8-16		
	Findings include:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00731	B. WING		12/3	31/2015
_	PROVIDER OR SUPPLIER	200 EAST	ORESS, CITY, S NINTH AVE TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	R46's physician's prindicated diagnoses lumbar region, seps The physician's prohistory of diverticuling R46's admission Mi 9/24/15 identified a Status score of 13/area assessments of R46's care plan, da cognitive impairment return to the common R46's September 2 revealed R46 had radication admistered on 9/26/1 licensed practical in the medication administered on 9/26/1 licensed practical in the medication had since supper. No for effectiveness was centry dated 9/26/15 had received another stomach and emes listed as had another the other doses administered on 9/25/15 at 8:30 a.m. and complaints of mindicated R46 had be indicated R46	rogress notes, dated 9/18/15 of spinal stenosis of the sis, and urinary tract infection. gress note also identified a tis of the colon. Inimum Data Set (MDS), dated Brief Interview for Mental 15 (cognitively intact). No care were completed with the MDS. ted 9/30/15 identified no nots and that R46 desired to unity. O15 medication sheets eccived Maalox (an antacid) of ate, as well as one dose at 5. Notations documented by urse (LPN)-A, on the back of ministration record for a dose 25/15, at 2:00 a.m. indicated been given for stomach upset completed. A subsequent completed. A subsequent at 2:00 am. indicated R46 er dose of Maalox for an upset is; the follow up result was er emesis at 4 a.m. None of ministered had follow up	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING: A. BUILDING:	(X3) DATE SURVEY COMPLETED	
00731 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 SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) BY TAG (EACH CORRECTIVE ACTION SHOWN TAG) CROSS-REFERENCED TO THE APPROPRIED TO THE APPR	ULD BE COMPLETE	
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/3	31/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVEI	=		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 28	2 830			
	at 1:56 a.m. indicate distended, his bowe and he had been had BM. R46's temp wat 99.1 degrees F.	note by LPN-A, dated 9/26/15, ed R46's abdomen was el sounds were difficult to hear aving emesis which looked like as noted to be slightly elevated note written by LPN-A on n. indicated R46 had 100 cc's				
	movement) with no indicated R46 was a slightly elevated ten	26/15, at 4:48 a.m. indicated R46 had 100 cc's emesis, like soft formed/loose BM (bowel ovement) with no odor. The note further dicated R46 was cool and clammy, with a ightly elevated temperature at 99.1 degrees F. 46 had a wastebasket beside him, and ontinued to wretch.				
	9/26/15, at 9:57 a.m further emesis of gr of BM looking in it. an acute care hosp order was received emergency room (Eindicated R46's date	note entered by LPN-B, dated n. indicated R46 had two reenish liquid thick with pieces In addition, the note indicated ital had been called and an to transfer R46 to their ER) via ambulance. The note ughter was updated and had at the hospital. R46 left the				
	present in R46's red	order dated 9/26/15 was cord and verified the physician r ambulance to the acute care				
	9/26/15, at 2:06 p.m admitted to the acu	ng progress note dated n. indicated R46 had been te care hospital with a obstruction, and would need				
	A faxed physician's	order sent on 9/25/15, at 6:05				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	p.m. from the facility identified that R46 hexperienced several throughout the day drink. R46 complain had not been signed days later, when the responded with a statelephone order to the Please do NOT fax need attn [attention [physician] - today staxing for response. The ER progress note a.m. was reviewed. had appeared distressed uncomfortable with dried brown matched been uncomfortable with dried brown matched appeared distressed in the error of the erro	y to R46's primary physician had emesis since 8:30 a.m., al rounds of hiccups and had been unable to eat or ned of feeling weak. The fax d off until on 9/28/15, three enurse practitioner (NP)-A statement including, "Noting transfer to ER on 9/26/15. In regard to situations that that day. This will be sent to 8/28/15. Please review the procedure. Thx [Thanks]." The ER note indicated R46 essed when examined, had a, and had dry oral mucous aterial on the tongue and lips. In indicated R46's abdomentally distended, mildly tender bowel sounds. In addition, of brown liquid had been stomach after the insertion of R46 had received 2000 ml of renous for hydration. The ER dicated R46 had appeared and verified the admitting bowel obstruction and severe thurse's assessment dated m. indicated: R46 had stated for the last two days and his own like stool. R46 had sin the ambulance enroute to nit was described as dark gout of his mouth. R46's firm, with no bowel sounds	2 830			

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_				3) DATE SURVEY COMPLETED		
		00731	B. WING		12/3	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC	200 EAST	DRESS, CITY, S NINTH AVEI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	complained of abdorate the pain. R46 nasogastric tube for fluid output after whoetter. R46 was also what ever we have The hospital discharindicated R46 had used to correct the small developed subseque anticoagulation is suited in the control of a nasogastric tube were initiated and Fouring interview on director of nursing (expected staff to commediately with the especially when the BM-type material and During interview on nursing home's head coordinator/nursing LPN-B was not well hospital intensive contention in the time of the incident of the inciden	ominal pain but was unable to had his stomach drained via a reten minutes with 1400 mL of hich R46 stated he felt much ert and "states we should do to do. Is comfortable now." Trage summary dated 10/5/15, undergone abdominal surgery bowel obstruction, and had lent cardiac and less as well as post-operative normal bowel motility) after the resolved with the replacement be; however, comfort cares R46 passed away on 10/5/15. 12/29/15, at 3:07 p.m. the DON) verified she would have entact the on-call doctor er urgent clinical issues, a resident was vomiting and not feeling better.	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00731	B. WING		12/3	31/2015
NAME OF PROVIDER OR	SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		200 EAST	NINTH AVE	NUE		
VALLEY VIEW MANO	OR HCC	LAMBERT	TON, MN 56	152		
PREFIX (EACH I	DEFICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830 Continued	From pa	ige 31	2 830			
stated she contact/ca directly with administration staff to che status, apply a physical she though her judgmevery Thu. When LPN on 12/29/11 received received received received recomplaints. She was a been eating administer thought the first time so LPN-A verelike stool be abdomen LPN-A was complained subsequentlater in her she'd becomplained said she'd paperwork not call the her conceived along the nurse, LPI	e would hall the on- th concer ator stated eck the v petite and assessm ht LPN-A ent. She rsday nig N-A was i 15 at 4:02 eport fror 5, regardi ware a fax ed worked was awar s of not fe aware R4 ng well, all red Maalox she admir iffied R46 out there had also s unawar ed of pain ntly vomit r shift (are of word y wrong w proceed c for a ho e RN on c rn. LPN- paperwon N-B, who	ave expected staff to call and/or primary physician ins that were urgent. The d she would have expected the ital signs, bowel movement d fever status while conducting nent. The administrator stated was a good nurse and trusted further verified LPN-A worked	2 830			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
			ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 32	2 830			
	an assessment to for During the interview there had been a his she had noted when pass along to the domain a.m. the administra notified the physicial symptoms, and that there had been a dophysician notification. During interview on medical director was would have expected they filled out the path of the pospital. The medical director.	ollow up on R46's condition. v, LPN-A stated she thought story of small bowel concerns in filling out the paperwork to ay shift personnel. Interview on 12/30/15, at 9:12 tor stated LPN-A should have an sooner about R46's it she had not been aware elay in his nursing care and				
	anyway, prompt me him comfortable. T effect of delayed me related to R46's me	edical care would have made the medical director stated the edical care/interventions edical outcome was difficult to a not his usual physician.				
	medical doctor (MD stated he would have called the clinic and R46 began vomiting stated faxing medic p.m. was inappropring attended at that he'd been concerned ischemic bowel when due to the delay in after his symptoms made some "deprese hospital transfer on	12/31/15, at 9:27 a.m. b)-A (R46's usual physician) we expected staff to have d/or the on-call physician when g stool-like material. MD-A cal staff at the clinic at 6:00 iate as the fax machine was time of day. MD-A stated ed about the potential for en R46 arrived at the hospital, receipt of medical attention began. MD-A stated R46 had ssed" comments prior to the 9/26/15, but those comments ad were not relevant to this				

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00731 B. WING 12/31/2	
	/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 SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 SI 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,	

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AND BLAN OF CORRECTION \ IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00731	B. WING	·····	12/3	1/2015
	PROVIDER OR SUPPLIER	200 EAST	DRESS, CITY, S NINTH AVE TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Insulin Glargine So subcutaneous (SQ) sliding scale with R unit/ml. BS reading diabetic educator w listed for notification hypo (low) or hyper During interview on licensed practical n were no protocols, notify the medical dLPN-C stated she whow the resident fe BS-which she ident 500's". On 12/30/15, at 2:3 would notify the MD above 600 mg/dL. 12/29/15, the supper mg/dL and the MD further stated R21 fabove 400 mg/dL aread to give 6 units was greater than 35 when the glucometr of a BS over 600 m the nurse on call at reading. During interview on diabetic educator in reports of R21's BS the clinic has a protadjustments and th were based upon. stated R21 had a himself.	ge 34 Jution 100 unit/ml- 24 units one time per day (QD), and egular Humalog solution 100 us were to be faxed to the eekly. No parameters were of the physician regarding (high) glycemia (BS). 12/30/15, at 3:10 p.m. a urse (LPN)-C indicated there or orders, indicating when to octor (MD) of BS levels. would notify the MD related to it and if there was a high ified as "way above 400's- 6 p.m. LPN-D stated she of she obtained a BS result LPN-D confirmed on or BS check for R21 was 521 was not updated. LPN-D requently has BS readings and the facility standing orders of regular insulin if the BS omg/dL. LPN-D indicated or read "high" it was the result g/dL and she would telephone the hospital to report the 12/30/15, at 2:57 p.m. the dicated she received weekly ocol for diabetic medication is was what insulin changes The diabetic educator further istory of being a brittle diabetic ere supposed to call the	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/3	31/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	related to changes educator further indicated she had be recently discharged 12/5/15. She indicated have been determined buring interview on and RN-C stated the for reporting BS readocumentation on the and stated that would followed unless indicated that would written. RN-B indicated symptomatic she with based on the stand and RN-C indicated Change in Conditional reporting of BS readonal RN-B stated, "we will we were yone is aware of the conditional reporting of BS readonal RN-B stated, "we will we were yone is aware of the conditional reporting interview on indicated she had be a months at the factor on BS checks which area, wear gloves, are sident had ordered specific insulin order specific insulin or	in status. The diabetic licated she thought BS en identified when R21 was from the the hospital on ated the parameters would ned by the discharging MD. 12/30/15, at 3:12 p.m. RN-B ere were facility parameters adings. They referenced the he facility's standing orders ald be the practice they exidualized orders were ated if a resident was could notify the physician ing order instructions. RN -B I they were not aware of the n policy related to immediate dings above 430 mg/DL. ill have to make certain	2 830			

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-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/3	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC	200 EAST	DRESS, CITY, S NINTH AVEI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	On 12/31/15, at 9:0 the facility's medica resident would have from the hospital for physician stated R2 before admission to history of blood sugthat the resident was when her blood sughowever, stated if so for an elevated blood provide specific ord required to recheck results. She stated, 'hi' because they has blood sugar is below to initiate the hypogindicated she would and/or on-call staff were outside range. When interviewed a director of nursing (2015 documentation indicated she was used for the staff in accordance when to Report to staff in accordance when to Report to staff in Condition MD/nurse practition last revised 3/15, in than 430 mg/dL (or diabetic patients us	4 a.m. R21's physician, also I director, stated typically a a specific order that comes r sliding scale insulin. R21's at had been her patient even the nursing home, and had a ars fluctuating "all over" but as usually most comfortable ars ran over 300 mg/dl. She'd received a telephone call ad sugar level she could ers as to when staff were the BS and call back the "they call if the meter reads are nothing to base it off. If the w 70 mg/dL staff would need lycemia protocol." She further I expect staff to notify the clinic to update on BS readings that an an 12/31/15, at 1:00 p.m. the DON) reviewed the December of R21's BS readings and anaware of the wide fluctuation and she would have expected tending MD and/or the on-call with the Change in Condition the MD/NP/PA policy.	2 830			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/3	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE	, -	
VALLEY	VIEW MANOR HCC		NINTH AVE			
(VA) ID	QUIMMA DV QTA	TEMENT OF DEFICIENCIES	ON, MN 56	PROVIDER'S PLAN OF CORRECTION	- NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 37	2 830			
	practitioner (NP)."					
	8:50 a.m. the DON understand or be un communicated using expressions. The facility diagnos admitted to the facility diagnos admitted to the facilincluding dementia with a cognitive con R6's annual MDS arevealed the reside cognition with daily intruded on the priviple behavior towards of not directed towards than daily. The MD extensive assistant locomotion on/off upersonal hygiene. The modern of the priviple in the resident of the priviple in the priviple i	ssessment dated 10/9/15, nt had severely impaired wandering that significantly acy of others, physical thers 1-3 days, other behavior s others 4-6 days but less is also indicated R6 required se with bed mobility, transfer, nit, dressing, toilet use, and The MDS further indicated nor family/significant other te the daily and activity				
	falls related to (r/t) had weakness, gait/bala incontinence, hearing impaired cognition, needs. Intervention meet needs, encour exercise, physical as improved mobility, at three times daily, rewall or objects, use The care plan further	d 10/12/15, indicated a risk for nistory of falls, generalized ance problems, bladdering and vision impairments, and difficulty communicating instinctions included: anticipate and rage activities that promoted activity for strengthening and ambulate with staff in hallway edirect when wheeling close to distraction when restless. For identified a communication deficit and head injury.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/3	1/2015
	PROVIDER OR SUPPLIER	200 EAST	ORESS, CITY, S NINTH AVE TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Interventions included resident/family condecommunication diffice were unable to communication of the progression of the effectiveness of condectiveness of	ed: discuss with cerns or feelings regarding culty, family reported that they imunicate with resident due to his dementia, observe mmunications strategies and as continuously observed from as observed being ambulated hird pushing the resident's hind him down the west. The resident was cooperative lithough could not be and smiled to the staff, who in sident. After walking the resident was assisted back ont of the television (TV). R6 self throughout the dayroom in brought R6 a sensory item a shape and consisted of llow tubes held together with a the object to be stretched and occepted the item, talking out NA- walked away. R6 held appear interested, nor did he	2 830			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	nurses' station. LPN away from the area room. -At 1:52 p.m. R6 proto the drinking found had a plastic mug awater from the found approached R6 and mug with water them mug. R6 accepted to mumble out loud west hallway toward Once R6 made it to intercepted the resignom. -At 2:00 p.m., R6 work covers without shoer resident was holding legs. R6 eyes were left.	arted to propel behind the A-C redirected the resident and then assisted him to his opelled himself out of his room tain in the west hallway. R6 and was attempting to obtain tain. A staff member assisted him with filling the preplaced the cover on the the water mug then continued and propel himself down the disthe administrative offices. The end of the hallway, staff dent and returned him to his as lying in bed on top of es. A sensory item the greatlier was on the resident's ewide open.	2 830			
		as seated on the edge of his vas off his foot, as he held his ed out the laces.				
	bed in room attemp left shoe. Coffee so was being conducte time. At 2:56 p.m. F bed having success his shoe. At 3:10 p.	ontinued to sit on the edge of ting to pull the laces out of his ocial and word games activity ed in the dining room at that R6 continued to sit on edge of sfully removed the laces from m. NA-C entered R6's room ained medication aide				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	1 1 2/9	.,
VALLEY	VIEW MANOR HCC		NINTH AVE			
	T		ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 40	2 830			
	resident was still "wasked if R6 was sul TMA-A responded tand on the resident chair and not worry p.m. R6 seated on unlaced shoe. A we begin at 4:00 p.m. (was still on the edg re-lace his shoe. T continuous since 2:	e room and asked if the vorking on his shoe." NA-C posed to have the shoe. that if she could get it laced, then they could put him in his about it. On 12/29/15, at 3:57 side of bed examining the ellness group was scheduled to On 12/29/15, at 4:17 p.m. R6 e of the bed, attempting to his activity had been 30 p.m. or nearly two hours.				
	significant staff to re the three hour conti 12/29/15. The resid object though staff could be used or sp Staff provided mining continually redirected	esident communication during inuous observation on dent was handed a sensory failed to model how object bend time with the resident. The mal interaction with R6 and and him to his bedroom and bed though the resident was				
	following times: - At 7:50 a.m. R6 w the corner of the dir independently. The	as seated alone at a table in ning room eating breakfast table was pushed flush to the 86's back was to the other ed the wall.				
	to the Cityside dayr table. Staff handed shaped sensory ob when manipulated. without further inter behind him on the s	as assisted in the w/c by staff oom and was situated at a IR6 a multicolored cylinder ject that also made sound Staff then left the area action. R6 placed the object seat of his w/c and proceeded ast the nurses' station towards				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	the dining room to t LPN-C was standin understood, he voc R6 he had already resident back to his resident's room at 8 bare mattress and p The bedding was pi was holding onto the up in bed. -At 8:25 a.m. R6 was bed and the w/c was the brakes locked. located on the seat was wearing shoes the side of the room surveyor alerted the walking by to quest of independent amb stated R6 did some redirected R6 to his administrator asked oxygen (O2) as he oxygen (O3) as he oxygen (O4). The hall of the housekeeping (Hsp redirected R6 back hall. Upon enter thousekeeping (Hsp redirected R6 back himself down the word the activity room. R himself down the word the corner, the administration back himself down the word the corner, the administration back himself down the word the corner, the administration back himself down the word the corner, the administration back himself down the word the corner, the administration back himself down the word the corner, the administration back himself down the word the corner, the administration back himself down the word the corner, the administration back himself down the word the corner, the administration back himself down the word the corner, the administration back himself down the word the corner, the administration back himself down the word the corner, the administration back himself down the word the corner of the	he medication cart where g. Although R6 could not be alized loudly. LPN-C informed eaten and assisted the room. LPN-C left the 3:05 a.m. R6 was lying on the billow without a pillowcase. Illed at the end of the bed. R6 e grab bar, attempting to sit as seated at the edge of the spositioned next to bed with R6's tennis shoes were of the w/c. At 8:36 a.m. R6, and was ambulating along as he felt the wall. The eadministrator who was ion whether R6 was capable bulation. The administrator times ambulate, and wheelchair. The IR6 whether he needed his was heavily breathing. The a nasal cannula and the eroom. Semoved the 02 tubing, om the room via the w/c and sident's room located across wing the doorway, kg)-A intervened and	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	himself around the to look out the wind fish tank. R6 propel direction of the east here until 10:30 a.m the east hallway to dayroom. No verbainteraction was noted and was identified or planned intervention seated in w/c in City station when the act dayroom, said "Hi" on the TV and walk remained seated at dining room with his residents. -At 2:16 p.m. NA-B R6 to ambulate, how stand when prompt seconds. The trans staff left the resident staff left the resident while located in the room, partitioned of R6 was offered his routinely had been after the main when R6 finished haround the front are designated table. Note the stand when prompt seconds are a of the dining row while located in the room, partitioned of R6 was offered his routinely had been after the main when R6 finished haround the front are designated table.	perimeter of the area, pausing ow and watched the fish in the led himself toward the thallway and remained seated in LPN-C then moved R6 from a table located in the all communication nor ed between staff and R6. Was seated in w/c in dayroom a wellness activity in process on the plan of care as an in. At 11:27 a.m. R6 was yside dayroom near nurses stivity director (AD) entered the to R6, turned up the volume ed away. At 11:48 a.m. R6 in the table in the corner of the se back away from the other and NA-A attempted to assist wever, the resident did not ed for approximately 30 sefer belt was removed and the	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
		00731	B. WING		12/3	1/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
VALLEY	VIEW MANOR HCC		NINTH AVE FON, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 43	2 830				
		room at 2:44 p.m. When 10/15, at 12:41 p.m. the AD 11:41 tion barrier.					
	TMA-A indicated th communicate with tattempted any alter	he resident and had not native method, and said it was A said R6's family visited					
	licensed social work they were unsure we able to talk to his fat Although they had re	on 12/31/15, at 8:50 a.m. the ker (LSW) and DON stated whether R6 would have been willy on the telephone. The hever attempted to assist him y, they said it would be worth					
	DON confirmed the returned to his room wandered. The DO informed the reside a bare mattress, lin bed, and no pillowo agreed staffs' interview.	on 12/31/15, at 1:25 p.m. the R6 should not have been or put into bed when he N stated, "That's sad" when not had been put into bed with en pushed to the end of the ase on the pillow. The DON ventions and/or lack of intions was concerning.					
	director of nursing of system to educate a system to ensure significant providing cares as of residents. The discould monitor for comedical records. T	THOD OF CORRECTION: The or designee could develop a staff and develop a monitoring taff are monitoring and necessary to meet the needs irector of nursing or designee ompliance through audits of he results of these audits ented at the quarterly QA&A					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	31/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 44	2 830			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
2 965	MN Rule 4658.0600 -Nutritional Status	Subp. 2 Dietary Service	2 965			2/8/16
	must ensure that a which supplies the determined by the dassessment. Substitute of the control o	nal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food				
	by: Based on observati review, the facility fa were implemented	ent is not met as evidenced on, interview and document ailed to ensure interventions to prevent significant weight ents (R28) reviewed for		Completion Date: 2-8-16		
	Findings include:					
		er sheet dated 7/1/15, including stroke, chronic dementia.				
	12/11/15 revealed F the past month or 1 residents current we eating problems. Th had experienced a	num Data Set (MDS), dated R28 had a weight loss of 5% in 0% in the past 6 months. The eight at 150#. No chewing or ne MDS further identified R28 weight loss of 20# pound (lb) MDS dated 9/16/15, of a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00731	B. WING		12/3	1/2015
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY VIEW MANOR HCC		NINTH AVEI			
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
Review of the most curre R28 as having potential report to dementia and decreas Interventions listed including residents weights and residents weight loss and to eat in a calm setting. Review of R28's log of weloss from 170 to 150 lbs. (3 month period). Review of R28 nutritional 10/14/15 indicates the resident eats a his meals and is on a regor swallowing problems. Review of R28's minier nutritional to the resident eats a his meals and is on a regor swallowing problems. Review of R28's minier nutritional to the residents for any has not declined. The weight loss of 20# in the risk for malnutrition. No or documented related to the residents food intakes meals. Average daily intated to the resident food intakes the months of 11/15 and R28's most current dietar completed by the dieticial the resident's significant to related to the residents in the residents	ent care plan identified nutritional problems due ded cognition. de: staff assist to set up the residents intake and exphysician, monitor the port to the physician any defended and the physician and the physician and allow the resident time of allowing the physician and the physician and the physician and the physician and the resident is showing a past 3 months and is at the physician to the previous 3 and the physician physician physician physician physician physician physician physician and the physician	2 965			

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	PROVIDER OR SUPPLIER	200 EAST	DRESS, CITY, S NINTH AVE TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 965	requiring more assist meals. No recommoduring interview with 12/29/15 at 2:00 p.r of who was responsive weights, but confirm most current MDS at triggered/identified. The DD stated R28 discussed with the 12/15/15, but the R recommendations. During observations 12/30/15, at 8:00 a. resident his meal. This meal but did not The resident received diet with no chewing. During interview with at 8:00 a.m. she con R28's significant we nursing staff indicated probably due to his more assistance with included she did not intervention nor recoloss due to the resident weight loss if they follow up the following questioned, the RD weight loss should staff for causal faction interventions.	stance with setting up his endations were provided. th the dietary director (DD) on m., indicated she was unsure sible for monitoring R28's ned she had completed the assessment which R28's significant weight loss. 's weight loss had been registered dietician (RD) on D did not provide any so of R28 eating breakfast on m. staff were feeding the The resident consumed 90% of a participate in the process. Yed a regular mechanical soft gor swallowing problems. the the facility RD on 12/30/15, infirmed she was aware of sight loss and stated the led R28's weight loss was dementia and he required the eating. The RD further to recommend any type of commendation for R28's weight dents body mass index (BMI) ranges. The RD further concerned about a residents all within their BMI, but may ang month. When further did confirm R28's significant have been addressed by the				

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	LETED
		00731	B. WING		12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
			NINTH AVE			
VALLEY	VIEW MANOR HCC	LAMBERT	ON, MN 56	152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965 21435	director of nursing of revise current polici weight loss and rest director of nursing of responsible staff on audit to ensure all of being carried out with The director of nursiaudits for compliant assurance committed. TIME PERIOD FOR (21) days.	or designee could review and es and procedures related to idents nutritionally at risk. The or designee could educate the policy changes as well as turrent recommendations are thin the dietary department. Sing or designee could conduct the could review with the quality	2 965			2/8/16
21435	Recreation Program Subpart 1. General home must provide recreation program based on each individed strengths, and need meet the physical, right well-being of each right comprehensive resistant and developmental planning and developmenta	al requirements. A nursing an organized activity and . The program must be vidual resident's interests, ds, and must be designed to mental, and psychological esident, as determined by the ident assessment and of care required in parts 58.0405. Residents must be ies to participate in the opment of the activity and	21435	Completion Date: 2-8-16		2/8/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00731	B. WING		12/3	1/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC	200 EAST	DRESS, CITY, S NINTH AVE FON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	R6 R6 was admitted to diagnoses including disturbance, cognitic chronic obstructive muscle weakness a facility diagnosis report of the season of the assessment dated impaired cognition of the significantly intruded physical behavior not directed less than daily. The neither the resident could complete the portion of the assess of daily and activity resident preferred resident preferences of the control of the preferences of the control of	the facility on 9/5/14, with gementia without behavioral ve communication deficit, pulmonary disease (COPD), and difficulty walking per the bort. Im Data Set (MDS) 10/9/15, indicated severely with daily wandering that don the privacy of others, owards others 1-3 days, other ed towards others 4-6 days but the MDS further indicated nor family/significant other daily and activity preference sament. The staff assessment preferences indicated the ecciving a tub bath, snacks ying up past 8:00 p.m., family involvement in careing to music and spending time attended to music and spending time defined the ecciving and spending time attended to music and spending time attended to music and spending time defined to music and spending time generation programs with a school kids singing, golf cart son/on phone with family, e assessment also included watching wrestling on TV and	21435			
	indicated the reside	ent was primarily independent eded some guidance with				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS. CITY. S	STATE, ZIP CODE	1 12/0	172010
VALLEY	VIEW MANOR HCC		NINTH AVE			
VALLET			ON, MN 56			T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 49	21435			
	wellness. Intervent plan: (1.) CD player in rorresident's desire. (2.) Recreation/Welexercise, listening twrestling and warm sensory and 1:1 tim (3.) EMOTIONAL: (individual music en (4.) PHYSICAL: En Well-Fit program to individual cardio. Twould work on puzz period.	Offer ipod or CD player for joyment. courage participation in include group exercise and/or the activity goal indicated R6 eles in day room by the review				
	8:50 a.m. the direct R6 did not speak no further indicated sta resident through ge Continuous observa	on 12/29/15, at approximately or of nursing (DON) confirmed or understand English. DON aff communicated with the estures and facial expressions. ations of R6 on 12/29/15, from p.m., revealed the following:				
	- At 1:16 p.m. R6 w assistance of two s residents wheelcha west Cityside hallwa English to his vocal the length of the ha w/c, removed the tr him to the dayroom station. Staff move and then R6 propel throughout the dayr	as ambulated with the taff, a 3rd staff pushed the ir (w/c) behind him down the ay. Staff were responding in izations. After R6 ambulated Il staff seated him back in the ansfer belt and transferred area located by the nurses'd him in front to the television led himself in the w/c				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00731	B. WING		12/3	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC	200 EAST	DRESS, CITY, S NINTH AVEI ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	of multiple-colored with a bungy type of be stretched and mitem, talking out lou held the item, he did he attempt to manip NA-A left the area at R6. R6 remained in p.m., when licensed assisted him back to the attempt to manip not the properties of the properties o	hollow tubes held together ord. This enabled the object to anipulated. R6 accepted the d constantly. Although R6 d not appear interested nor did bulate or pull the sensory item. after the item was delivered to a the commons area until 1:44 d practical nurse (LPN)-C o his room. It his room via the w/c to blastic mug from the drinking the west hallway. Staff he task, replaced the lid and a water-filled mug, R6 to as he propelled the w/c way. It was noted that once R6 f the hallway, staff intercepted	21435			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00731	B. WING		12/3	31/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC	200 EAST	DRESS, CITY, S NINTH AVE TON, MN 56	=		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	games activities we this time, R6 was no attend. At 3:10 p.m greeted R6. Traine also entered the roo still "working on his whether R6 was su TMA-A responded to and on R6, they couland not worry about assist R6. Observations of R6 following: - At 7:50 a.m. R6 we table in the corner of breakfast independ flush to the wall on the other resident's the wall. At 7:58 a by staff to the Citystable. Staff handed shaped sensory object without further interbehind him on the sto propel self past to dining room to the rowas standing. LPN had already eaten a back to his room. Lat 8:05 a.m. R6 was bare mattress exported the end of bed; no proper self past in the corner of the room. Lat 8:05 a.m. R6 was bare mattress exported hattempting to sit up -At 8:25 a.m. R6 was already eaten at the proper self past in the corner of the room. Lat 8:05 a.m. R6 was bare mattress exported to sit up -At 8:25 a.m. R6 was already eaten at the proper self past in the corner of the room at the	ere held in the dining room at ot assisted or offered to a. NA-C entered the room and d medication aide (TMA)-A om and asked whether R6 was shoe". NA-C asked TMA-A pposed to have the shoe. that if NA-C could get it laced ald transfer him into his chair tit, however NA-C did not on 12/30/15 revealed the as observed seated alone at a of the dining room eating ently. The table was pushed 2 sides. R6 had his back to in the dining room, facing only m. R6 was assisted in the w/c ide dayroom and placed at a IR6 a multicolored cylinder ject that also made sound Staff then left the area action. R6 placed the object seat of his w/c and proceeded the nurses' station towards the medication cart where LPN-C -C responded to R6 that he and assisted in propelling him LPN-C left the resident's room as lying on his bed with the sed and bedding in a clump at billowcase was on R6's pillow. olding onto the grab bar,	21435			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
00731	B. WING		12/3	1/2015
NAME OF PROVIDER OR SUPPLIER STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
VALLEY VIEW MANOR HCC	T NINTH AVE			
LAMBER	TON, MN 561			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
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				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	31/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVEI ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	near nurses station entered the dayroor the volume on the 11:48 a.m. R6 rema corner of the dining resident's as noted -At 2:35 p.m. R6 was where the men's grain area of the direct were noted to interate out of the dining room at 2:44 p.m. When interviewed of AD stated R6 is verand is scheduled for further indicated the were scheduled for stated staff will also well as the men's grain that an interpret to the facility on 12/since. AD stated trainterpreter but calls stated a few weeks another facility campossible placement to converse with R6 discovered he enjoy. When requested do activities provided froted: (11/2/15 throtwo 1:1's with staff (11/16-11/22/15 R6)	ge 53 d in w/c in Cityside dayroom when the activity director (AD) m, said "Hi" to R6, turned up TV and walked away. At ained seated at the table in the room with his back to other during the breakfast meal. as observed in the dining room oup activity was held in the ning room. No activity staff act with R6 until they assisted om towards the direction of his on 12/30/15, at 12:41 p.m. the y "antsy" r/t group activities r in-room programming. AD at 2 in-room activity programs 20 minutes/day. AD also offer coffee social time as roup activity as well as three able to attending activities attend to attending activities attend to attending activities attend to attending activities and not been returned ying to get hold of the had not been returned. AD ago a representative from the to assess the resident for and the returned and the resident for and the resident for and the resident for and the resident for and the received only (11/4 & 11/7). The week of received 1:1 activity. Although the had provided 1:1 in-room	21435			

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-			(X3) DATE COMP	SURVEY LETED		
		00731	B. WING		12/3	1/2015
	PROVIDER OR SUPPLIER VIEW MANOR HCC	200 EAST	DRESS, CITY, S NINTH AVE TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21435	programming with F documentation to do implemented nor concurred. AD state headphones for R6 language. The AD indicating the lpod with November and 4 times when questioned a with when were reviewed to sure resident had attend highlighted and/or of had been involved in observations. When further intervials. When further intervials and the AD was undicated R6 attend the AD stated he did activity sheets foil days of documentation was documentation was R23 R23 was admitted of including: demential disorder, and chron disease (COPD) per The report further in the concurrence of the with the proposition of the with th	R6, she was unable to provide emonstrate this had been old she recall when this had d she offered an Ipod with to listen to music in his own then provided documentation was offered 5 times in mes in December 2015. It is is incovered being unaware of these in the current activity sheets abstantiate the activities each ed, there was nothing documented indicating that R6 in activities during the days of it is is incovered by it is	21435			

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NAME OF PROVIDER OR SUPPLIER VALLEY VIEW MANOR HCC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MANOR HCC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MANOR HCC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MANOR HCC (EACH DEFICIENCY MANOR HCC SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SANDLID BE PRECEDED BY FULL PROVIDE SEARCH CORRECTIVE ACTION SANDLID BE PRETATE ACTION SANDLID BE PRETATE ACTION SANDLID BE DEFICIENCY) 21435 Continued From page 55 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 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) EMOTTONAL: Offer ipod or CD player for individual music enjoyment. (4) ENVIRONMENTAL: Observe (resident name) body language related to over stimulation [Resident name] is Unable to attend out of room events. (2) Province 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.		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
VALLEY VIEW MANOR HCC LAMBERTON, MN 56152 LAMBERTON, MN 5615			00731	B. WING		12/3	31/2015
CALLEY VIEW MANOR HCC CAMBERTON, MN 56152 CAMBERTON CAMB	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG EGULATORY OR ISC IDENTIFYING INFORMATION) 21435 Continued From page 55 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 dave books, magazines, newspapers to read, 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) "11 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.	VALLEY	VIEW MANOR HCC			_		
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."	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE	COMPLETE
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	21435	R23's quarterly Min assessment dated severely impaired of with locomotion on/assistance with bed toilet use, and personal resident was dependent was depende	imum Data Set (MDS) 11/6/15, indicated R23 ognition, total dependence off unit, and extensive I mobility, transfer, eating, onal hygiene. ange MDS assessment dated divity preferences as: very ooks, magazines, newspapers ant to do favorite activities, o outside and get fresh air od, and very important to us services or practices. It revised 11/9/15, indicated the ident on staff for structuring ties that promote wellness ognitive deficits. Interventions 1 bedside/in-room visits and it name] is unable to attend out in COGNITIVE: Encourage Ill groups and/or 1:1 OTIONAL: Offer ipod or CD imusic enjoyment. (4) in Observe [resident name] ited to over stimulation ited to over stimulation ited to over stimulation ited to over stimulation ited to activity walks, magazines, ited listening and playing music." continuously on 12/29/15, 3:56 p.m. while lying in bed. ite activity was held at 1:30 oom and the coffee social p.m. in the dining room. Staff ited to opportunity to attend either				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	10:03 a.m. R23 was Cityside dayroom a service was current room. At 10:21 a.m. R23 reyes closed. The Aresident seated in volumes station and attend church. R2:AD and the residen away and closed he area. NA-A then apto ask whether she nodded "yes". NA-A opportunity to attentransporting her to It at 11:08 a.m. R23 veyes closed while a process. She had reto attend this activit. At 3:12 p.m. R23 we closed. A music activities and NA-A conwith her morning catactivities, she often down. Both NA's conviction of the con	as a.m. until 10:23 a.m. At a seated in a geri chair in the ta table while a church ally being held in the activity remained in the geri-chair with aD approached another w/c located near the Cityside asked whether she wanted to a opened her eyes when the tall left for church but looked er eyes when they left the oproached R23 at 10:23 a.m. wanted to lay down. R23 A did not give her the d the church activity before the room.	21435			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00731	B. WING	····	12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	,	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
21435	Continued From pa	ge 57	21435			
	church though at tir during the service.	mes will become disruptive				
	AD stated R23's ac daily Sunshine grouimplemented twice on Saturdays). AD does fine while atte sometimes needed service as would ge would still expect R to participate in atte to located documer and 1:1's provided it.	on 12/30/15, at 1:40 p.m. the tivities included hair care, a up (sensory group) which is daily Monday-Friday and once stated the resident usually nding church service but to be removed from the et agitated. AD confirmed she 23 be offered the opportunity ending church. AD attempted ntation of activities attended for R23. The 1:1 activity 23 was to have 1:1's three				
	times/weekly. AD p from 11/2/15 - 12/5/ 11/16/15 - 11/22/15 7 occasions during 11/12/15, 11/13/15, AD confirmed the 1 and did not identify	provided 1:1 documentation /15 (minus the week of); R23 was provided a 1:1 on this period (11/5/15, 11/7/15, 11/27/15, 12/4/15, 12/7/15). :1 charting was inadequate the activity, time and/or ald not be able to evaluate				
	AD provided 10 day sheets for R23. The offered activities on unable to provide doffered in November activity sheets for Cosheets did not inclused participated or confirmed the chart incomplete.	on 12/31/15, at 10:21 a.m. the vs of December 2015 activity e sheets indicated R23 was a 5 of the 10 days. AD was ocumentation of activities er 2015 and provided 5 days of October 2015. The activity de evidence if the resident refused the activity; AD ting of activities was				
		ld train all staff to ensure each				

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 58	21435			
	honored, and then a occurring. Results or reviewed at the quarteristics.	I activity preferences are audit to ensure this is of these audits could then be ality assurance meetings. R CORRECTION: Twenty One				
21565	MN Rule 4658.1325 Medications Self Ac	5 Subp. 4 Administration of Imin	21565			2/8/16
	self-administer med resident assessmen care as required in 4658.0405 indicate	inistration. A resident may dications if the comprehensive ont and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.				
	by: Based on observati review the facility fa practice of self-adm	ent is not met as evidenced on, interview, and document illed to ensure the safe inistration for 1 of 2 residents erved self- administering a .		Completion Date: 2-8-16		
	Findings include:					
	Ipratropium-Albuter milligrams/3 millilite	ors dated 12/8/15, included ol solution 0.5-2.5 (3) ors, 1 vial inhale orally three ortness of breath, every 6 hours				
		ım Data Set (MDS) dated R6 had severe cognitive				
	Review of R6's care	e plan dated 10/12/15 included				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00731	B. WING		12/3	31/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21565	a risk for alteration (r/t) diagnoses of er obstructive pulmonacute episode. His h/o bronchospasms muscles in the wall difficulty breathing) identified a behavior included routinely retreatments. Further review of the include evidence of R6's ability to self-action of R6's abil	in respiratory status related to mphysema/COPD (chronic ary disease) with recurrent tory of (h/o) pneumonia, and is (sudden constriction of the is of the bronchioles causing. The care plan further or problem r/t dementia which refusing neb (nebulizer) The medical record did not is an assessment related to indminister medications. In p.m. two surveyors on the edge of his bed in the nebulizer solution is alone in the room with no visualization of the resident. Toroximately 2:50 p.m. licensed in the edge of bed though it is a possible to the properties on the edge of bed though it is a possible to self administer medication nurse was expected esident throughout a nebulizer rither confirmed C6 had a in-compliant with administration	21565			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21565	Continued From pa	ge 60	21565			
	Director of Nursing appropriate assess ensure the safe adr The DON could enson the importance of The DON or design resident records to and documentation could random audit left with residents u interdisciplinary tea could then be presemeetings.	CHOD OF CORRECTION: The (DON) or designee ensure the ments are conducted to ministration of medications. Sure the staff were educated of the assessment process. ee could randomly audit ensure adequate monitoring was in place. The DON could see to ensure medication is not nless deemed safe by the m. Results of these audits ented at the quarterly QA&A				
21695	Subp. 4. Houseke provide housekeepi necessary to mainta comfortable interior ceilings, registers, f and furnishings. This MN Requirements: Based on observatifailed to ensure 1 or reviewed with floor	Subp. 4 Plant eration, & Maintenance eping. A nursing home must ing and maintenance services ain a clean, orderly, and including walls, floors, ixtures, equipment, lighting, ent is not met as evidenced on and interview the facility f 5 rooms (Room 109, R6) or wall damage had bathroom maintained in good repair.	21695	Completion Date: 2-8-16		2/8/16
	Findings include:					

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE COMP. A. BUILDING: (X3) DATE COMP.		SURVEY LETED			
		00731	B. WING		12/3	31/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21695	on 12/31/15, at 8:30 hole approximately sheetrock at the basis adjacent to the turbular dispersion of the stated, "tub has damaged wall in the stated, "tub has damaged the resident tub room was adjact maintenance directs size hole in the wall dispenser and agreed did not create a hormaintenance directs policy/procedure burequest on the clipb problem to be fixed SUGGESTED MET The administrator or review, and/or revisensure resident roo good repair. The administrator or repair.	of bathroom in room 109 (R6) 0 a.m. it was noted to have a 15 inches by 4 inches in the se of the bathroom wall which ib room. and interview on 12/31/2015, intenance director confirmed in the bathroom of room 109. been leaking and this has ent's wall". He indicated the sent to R6's bathroom. The or further confirmed a quarter below the toilet paper ed the areas in the bathroom melike environment. The or could not provide a at indicated staff would fill out a board when there was a	21695			
21975	MN St. Statute 144A Commissioner of H	A.10 Subd. 3 Inspection; ealth; Fines	21975			2/8/16

iviinnesc	<u>ita Department of He</u>	alth			_	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00731	B. WING	 	12/3	1/2015
NAME OF I		CTDEET ADI		STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
			ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
21975	Continued From pa	ge 62	21975			
	correction order and and copies of any of commissioner of he human services und 144A.05 shall be ked and shall be made person upon reques provided by this subcorrection order and received by the nurrecent inspection of in a conspicuous arthe nursing home. notices of noncomphome owned and of political subdivision and posted at the fit governing body after Confidential information 13.05 or 13.46, shaposted as provided	posting. A copy of each d notice of noncompliance, locumentation supplied to the ealth or the commissioner of der section 144A.03 or ept on file at the nursing home available for viewing by any st. Except as otherwise odivision, a copy of each d notice of noncompliance sing home after its most or re-inspection shall be posted and readily accessible place in All correction orders and oliance issued to a nursing operated by the state or of the state shall be circulated arst public meeting of the er the order or notice is issued. Eation protected by section all not be made available or in this subdivision unless it able or posted in a manner ter 13.				
	by: Based on observati review the facility fa current survey resu readily accessible to visitors. This had the	on, interview, and document liled to ensure the most lts were posted in an area or residents, families and repotential to affect all 40 residing in the facility.		Completion Date: 2-8-16		
	Findings include:					
	During the initial tou	ur of the facility with the				

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Minnesota Department of Health STATE FORM

If continuation sheet 63 of 64 ZNOX11

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00731	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE FON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21975	director of nursing (p.m., observations and state survey recresidents, families of the results are usual board near the north but confirmed they looking for the survethem to be in a 3 rir south nurses station. The binder which in not visible nor easily families or visitors. SUGGESTED MET The administrator of staff to assure the fraccessible to all residesignee could more	ge 63 DON) on 12/28/15, at 12:00 revealed the current federal sults were not available to or visitors. The DON indicated ally posted on the bulletin h and south nurses stations, were not. After 15 minutes of ey results, the DON found in gibinder placed behind the in the residents chart stand. Included the survey results was y accessible to the residents, The DON confirmed this. THOD OF CORRECTION: It designee could re-educate acility survey results are sidents. The administrator or initor for continued compliance. R CORRECTION: Twenty-one	21975			

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